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* THE PHYSICIAN IN THE HUMAN COMEDY.

ISADORE DYER Ph.B., M.D.,
NEW ORLEANS, LA.

It was George McDonald, who made Donald Grant utter the quaint bit of humanism that 'the world moves by like an intricate panorama and we must sit and watch its progress, for he who reaches out to interrupt the pictures is liable to be hurt by the machinery.'

To the onlooker of modern civilization it is just that cycle of constant movement, with each turn rising to greater heights of knowledge, which makes us pause at the threshold of another era and, scanning the darkness of future endeavor, dream out the lines of coming achievements.

The generation which has brought some of us into the world has witnessed many wonders, beyond the imagination of our immediate ancestors; our children have not yet the vista of what they may realize. Already the first roseate hues of a coming dawn are lustrous with the tints of a glorious hope for a universal peace and the giant shadows of a ruinous armament are breaking before the strenuous rays of an international court of arbitration, developing under the genius of the greatest minds of the present day! The ferment of socialistic propaganda is fast throwing off the froth of its activity and is settling down to a steady development of a socialistic upheaval in which the betterment of the human race is to be the final result. Everywhere the reactionary movement is gaining ground and honesty is soon to flap its wings at the break of another day.

The skeletal forces of society are daily moving to the establishment of a structural rearrangement of the tissues of that society to the end that the evils of government and of commerce are bound to slough off as foul parasites on a body politic.

*Read before the Mississippi State Medical Assoeiation, Jackson, Miss., April 9, 1812.

Boodle, graft, and bumcombe have their day and even if Utopia is still in mirage, we can tell the difference between the glitter and the dross of our economic philosophies of to-day.

A broad survey of the history of the human race discloses a constant tendency to preserve community interests.

The particular form in which that has been accomplished has varied considerably from one period to another and with one race and another, but the elemental principles of economics have always been the same.

The term economics is comparatively modern in its present application and it has grown broader in its interpretation until it now applies to all those things which conserve the purity and preservation of the human race so far as the domestic, public and commercial relations are concerned.

Economics may be social, political, moral, religious, physical, or related specifically to any divisions of these heads and such use of the term applies to the forms, rules and customs and practices followed.

Students of medicine are particularly interested in economics, referring to the social and political phases, as applied to the field of medicine.

In principles medical economics is by no means new. Moses promulgated the practical application of these in his rules of conduct and of hygiene and sanitation. In the book of Leviticus, specific direction is given as to the qualities which determine food of fish, meat and fowl, as fit to be eaten; the disposition of diseases and of refuse was also distinctly taught and understood. The economics of the early Hebrew race were regularly practised under the direction of the moral teachers of the people, the priests.

Traces of Chaldean and Egyptian forms are still extant the world over in superstitions of medicine, referring the control or cure of diseases to formulæ to be repeated or chanted in set fashion to effect a result.

With the disseminating of customs and the interchange of these, various peoples acquired new forms in their rites and religious practises. Among the Chinese and Japanese the cults of India have laid on their Aryan practises and their customs in medicine and in religion are clear survivals of this early influence. The moral religions of Confucius and of Mencius, neither priests, but both philosophers, have lived by sheer force of truth in the midst of tradition.

The savage races carry emblems of their imagery in rites referred to stones, carved wood, forest groves and the like, all qualifying their rules of conduct, of health and of religion.

The modern school of medicine as we know it has come largely from Arabic antecedents—not to attempt a more remote history.

The influence of Greek and Latin culture, the spark of genius here and there illuminating large fields of the art and science of our subject—has gradually brought to us an accumulation of material which has had to be differentiated as it has been logically digested and understood.

With St. Luke, Hippocrates, Esculapius, Galen, and the mass of sacerdotal contributors, we have groups of early sponsors for a true art. Now and then the practise of medicine has been exploited, and advertised if you will, by notorious charlatans, like our Christian Scientists, osteopaths and quacks of to-day, but they have never possessed genius enough to illumine any pages of the history of medicine.

The logical law of supply and demand has always disposed of every problem as it has arisen and the years have necessarily been required to discover the causes of known truths; this has come about by the persistent perseverance of great and honest workers.

We have much to thank the early Spanish and Italian schools of Salamanca and of Salerno for, in making the early way for chemistry and anatomy. The secret cult of the alchemist Rosicrucians conserved the science of chemic art and the genius of Rabelais and Ambroise Pare made for organized medical study in the middle centuries of developing art.

To-day we stand on the pinnacle of a great height of achievement built by the labors of many minds governed at all times by the genius of truth, morality, and, above all, a humanitarian instinct.

No greater document in human history has ever been written than the oath of Hippocrates which formerly was recited by every graduate from a school of medicine as part of the ceremonial which gave the final degree. To-day it is accepted as the unwritten law which governs the practise of medicine and its ethics. The practical side of medical education and its ultimate purpose have so occupied the minds of the student and the profession that a halt is seldom made for a time long enough to look into the marches of sentiment and the graduate in medicine to-day has to grow older as his con-

tact with human nature brings him to a realization of other things than the business of medicine.

The purpose of medical practise is broad, aimed above all at the relief of human sufferings and the preservation of public health; the financial success in the occupation of medicine must come as secondary.

The young men in medicine of the present are just looking at the horizon of another day, promising a road of further labor and effort before any achievement can be measured.

Robert Louis Stevenson has written a story of a boy who was born as the son of a miller, and who lived in a valley surrounded by hills. This boy ("Will of the Mill") was full of ambition. Every traveler who came his way was the subject of his curiosity. He asked of the worlds outside his vision, and the pictures he made of what he would do when he grew to manhood were many and florid in their imaginative flights. One day an old man came his way and to the usual questions of the world beyond the valley, the old man made no immediate reply. He took the boy by the hand instead and walked him to the top of the nearest hill. "What do you see," he asked the boy. "Hills" was the reply. They walked up another and higher hill, the same question was put and the boy replied "More hills." As they walked back the old man, ready himself for the longest journey of all, pictured life to the boy and pictured the world outside as consisting of 'hills' and 'more hills'.

To the man who cannot rise to a vision of a land beyond the effort of "more hills," the vista of medical practise and its privileges must be always a closed book. The way is and must be hard, but success is measured always by endeavor.

It is calculated that forty per cent. of all graduates in medicine fail to qualify within the first five years after finishing college.

In our country there is now one physician to every six hundred people, and that ratio has been constant, or nearly so, for the last fifty years. The average annal income of the practitioner of medicine is about twelve hundred dollars, 'tho some make an hundred thousand, while others nearly starve.

There are crying evils in the practise which need correction and every man in medicine from this time on must buckle on his armor for the defense of his rights.

Quacks, faddists, unprincipled authors of medical pretensions or make believe medical schools, all fostered by a sym-

pathetic but ignorant public, and the unscrupulous but wise and dishonest parasites on our profession see the lines of least resistance and follow them.

Druggists usurp the field of medicine by pretending to know the treatment of disease through dispensing prescriptions they have stolen from their files, masking like Faust's boy Wagner, pretentions of a wider knowledge and discretion than his master claimed.

The new physician must learn to write prescriptions so that the druggist may not read ignorance in a dependency upon the compounds of proprietary concerns.

Time was when the occupation of the physician was held in so little esteem that he was held up to ridicule by the people and was made the bull of the playwright. *Gil Blas*, through the pen of Le Sage, satirizes the medical man of his day in exposing the shortcomings of Dr. Sangrado and his contemporaries. Moliere has used the medical profession as a type of character for a comedy mask and Eugene Sue has more modernly held up to ridicule one of his friends and teachers in medicine. But on such things the growth of the science has only thrived. The great anatomists and surgeons of three centuries have made the foundation on which our modern skill rests and the patient studies in the laboratory of our nineteenth century predecessors have made possible the brilliant discoveries of the last decade.

The physician has stripped off the pantaloon of the apothecary and has put on the armor of the true knight, battling for the preservation of his race, finding and fighting the causes of disease and developing the means through his own ingenuity and genius.

The whole field of sanitary science has grown out of medical research and the disease burdened islands of the Mexican Gulf and Caribbean Sea with the pest ridden death holes of the Central American coast have yielded to the intelligence of medical endeavor, enlightened by the genius of discovery and furthered by the glory of applied knowledge derived from the laboratory.

Preventive medicine has been given a high place in the economics of the human race, and the establishment of schools for the study of methods and for the spreading of the gospel of hygiene and sanitation must add more achievement and more glory to the profession which has found time to present this phase of life to a busy and commercially active world.

The study of diseases has brought about the necessity for the study of their effects and governments and states have gradually evolved systems of statistics for the study of mortality in its relation to civilization and its customs. Regulations of commerce have resulted, quarantine laws, more and more intelligent, have evolved, until to-day the comity of nations recognizes the need for the proper regulation of disease control. At the same time the workers in the laboratories have evolved protective medication, through serums and other means, to protect a public unfortunate enough to be afflicted with an epidemic disease. Already diphtheria, typhoid, cholera and the plague have been met by science and the future promises further aid from the laboratory.

Syphilis and leprosy, tuberculosis and cancer, the diseases of most horror to the popular mind, have been studied so as to-day to be so disarmed of their worst terrors that hope is written for each; the near future may provide both prevention and cure for all.

Every community of any size to-day is safeguarding the newborn by systematic study of the milk question and particularly its purity. Cattle are inspected for contagious disease and the milk itself is censored and in many cities certified.

Pure food laws and pure drug laws are gradually drawing the lines closer and closer around the flagrant violators of human trustfulness, and the education of the public in the necessity for its protection is also making for a better condition of healthfulness in the human race.

The world is meantime aiming at a universal peace, adjusting, in the dreamed of Utopia, all differences by arbitrament, using the wealth of nations to buy peace more cheaply than at the price of war.

Crime grows with civilization and the perversion of the human race rests upon the tripod of poverty, heredity and disease. The gradual distribution of the enormous wealth accumulation for the good of the poor may help the first; the education of the world in the laws of health, together with the enforcement of these, will still disease.

Heredity is too complex a problem for simple solution, but even here the world is working. The insane and criminals are now subject, in some countries and some states, to such surgical procedure as will prevent offspring. Enlightened countries and states, also, have promulgated laws preventing the marriage of persons afflicted with that constitutional and

contagious disease which may be spread to the other party through the marriage, or which may descend to the children. More than this, associated bodies of men and women are busily engaged in studying the problem of the preservation of the race, based upon the general laws of heredity, with the object of applying their conclusions to the practical training of the coming generation that future generations may profit. This field of eugenics, as it is called, must enlist the interest of every medical man as citizen as well as a student of physical and natural laws.

The lower animals have been both studied and improved in many of their types and it is more than interesting to speculate upon the ideal development of the human type under the conditions of training and environment for several generations.

The economics of medical practise and of the medical calling have many other phases, related to all the turns of the wheels of chance, calculated by the insurance actuary, weighed by the courts of expert testimony, concerned in the study of crime and its neurologic side, touching the field of the law at one time and of medicine at another. We are concerned in each of the world's fields of action, in war and in famine, at birth and at death, and where the lines of defense show signals of disease, the physician is at hand.

* * * * * *

Since Eve beguiled her better half, the world has traveled in constantly widening concentric circles, always paralleling the original circle of sin. Morals from the beginning have been the result of comparisons between good and evil and the viciousness of an offense has always been measured by the relative value in indignity or in result.

The survival of the fittest demands war and it demands utter war. This applies as much to races and to nations as it does to every day conditions, and war is simply a term which defines the friction of large bodies making to the same end. Substance is lost, energy expended, waste demanded and an ultimate approximated.

Civilization has developed more rapidly than have the conditions to meet it, with the result that the community interest in the advances made is evident and the right to enjoy it clear, but the modus is lacking. A natural interpretation results and those who are the stronger win either by righteousness

or by will and the weak suffer in a denial of what seems their right.

So as individuals, as types, as sects, as more or less organized bodies, the weaker grow into formidable enemies against society, as inherently constituted from a longtime strong and healthy growth. The resistance of any healthy body, organic or material, is definite and always alive to the demand upon it. It remains organized to meet opposing forces—so that as these arise there is unconscious resistance until a greater demand is made—for the reserve force. The psychic purpose and power of any combination of organic elements is greater than the average unit, so that the tendency to the combination is constant.

So it is that the individual either must submit to the conditions or suffer in antagonizing them. The man who is usually the exception in the multitude is not the one who opposes but the one who moves with it and who, at all times, feels the pulse of the people. The vainglorionsness of Cesar, the perversion of Nero, the selfish ambition of Napoleon, in each instance, overtook the leader, even though for a time, with all of these, the psychic side of the man showed the genius at the helm!

Success is measured solely upon the scales of the individual and the fulcrum is shifted with the point of view. With one individual the applause of the multitude suffices; with another, the signal comment of an authority recognized as superior is necessary; yet another considers the cost and the result as the measure of calculation and if the last is the greater, whether in gold or in glory, the end is won. The self satisfaction in a success, irrespective of the measure others place upon it, is seldom the case.

So it is that as the rules of determination are variable, so are the degrees of effort and so are, it must follow, the standards of merit.

The ambition for a cause, without calculation of the means, has always been the theory of a division of the humankind, and this division is large enough to include the inmates of penitentiaries and asylums, as well as those on trial.

The standard is uneven and, depending on the community, environment, and final issue of the individual, success is the reward and failure the punishment of the effort.

The standards for the morals of society are much like the old fashioned crazy quilt, held together by a variety of stitches,

often woven in by different hands and, according to the way you look at the work completed, there is presented one or another predominant figure, but all serve the same purpose—keeping the body comfortable. We decry the evils of the day; mark the parasites upon the community; even do away with them at times, yet they grow somewhere else and when the night is dull they creep in and lay new lines of attack against the forms of associated resistance.

Until the insane asylums are full, until the penitentiary facilities are exausted and until kindergartens of common sense are established, the ubiquitous fool and his natural affinities will continue to occupy the stage, affording material for the philosopher, and pabulum for the newsvendor.

It is of small credit to a man to jog on like Stevenson's "Will o' the Mill," at the end resting satisfied that his life had spun gracefully along meeting conditions as they came, letting them go by without remark and never going out to meet them. "More hills" was the echo of the old man's soul as the inverted scythe crossed his visage and the grim destroyer led him away. "More hills," and the fear of climbing them!

Success does not find the man—opportunity does; but he must watch for it and so guide opportunity that she travels with him along the road to success.

The potter finds his clay, but in his hand must grow the mold and in his fingers he must find the master skill which makes the form and which leaves the final product impressed with the spirit of his genius.

Each man is born with the natural instinct of success and most men miss the opportunity. Once I knew a music master who said that most people could sing if they could only find their note. He believed that every one was tuned to some particular key and until the particular symphonic circle was invaded the spirit of song was not there. I read a story once where the principal character was considered lunatic, until, during a great thunder storm, he was found playing the violin most beautifully, and as hard as the bow could draw, weeping the while; he had found his note.

The resourceful man makes opportunities and does not wait for them to overtake him.

The worldly measure of the man often falls short of the real value; many times it, on the contrary, puts him above his real value. The man himself is the only true judge and his

conscience measures him with more justice than any court of honor.

* * * * * *

When the final history of the world is written, the physician will stand alone in the variety of his economic usefulness, his field apart, yet touching at all times the toga of the citizen, the robe of the priest, the periwig of the advocate, the scarlet of the judge, the mask of the executioner—each shadowing his life with the mixed bitterness of reproach at the limitations of his ability in the midst of so great a field of labor and of so large possibilities of accomplishment, while always the whisper of the succored child, the prayers of the convalescent and the glory in sharing the salvation, bring the ray of light which lends the soft harmony of gentleness which should be the signal standard of the true physician, as at the end, he stands a sad and thoughtful actor in the Human Comedy.

Mississippi State Medical Association.

TO THE MEMBERS OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION:

April 22d, 1912.

Owing to acute illness during the last meeting of the Association I was unable to personally express my deep appreciation and gratitude for the great honor conferred on me by electing me as your president. I take this method of expressing my unbounded appreciation and I promise to do all within my power to make this a very successful year for the Association and I sincerely hope to meet every member at the next meeting at Vicksburg, so don't fail to come and bring a new member with you.

With deep gratitude, I am yours fraternally,

S. W. GLASS.

MINUTES OF THE HOUSE OF DELEGATES.

The 1912 session of the House Of Delegates of the Mississippi State Medical Association was called to order in K. of P.

Hall, Jackson, Monday, April 8th., at 8:30 P. M., by President D. J. Williams of Gulfport, the following members being in attendance:—Councilors Dye, Bullitt, Eason, Underwood, Johnston and Ullman; Delegates Beekman of Adams, Borroum of Alcorn, Walker of Chickasaw, Arnold of Choctaw, Ross of Forrest, Shepherd of Holmes, Reed of Itawamba, Rape of Jackson, Boswell of Jones, Reynolds of Lauderdale, Seay of Lawrence, Sandifer of Leflore, Elliott of Marshall, Grady of Monroe, Clay of Tallahatchie, Alexander of Tunica, Pou of Wayne and Catchings of Wilkinson; Secretary Howard.

Councilor Dye presented the following report from the Council:—

REPORT OF COUNCIL.

The Council met at noon April 13th. 1911, in K. of P. Hall, Jackson, and reorganized by electing J. B. Bullitt, University, chairman and T. M. Dye, Clarksdale, secretary. Present: Wallace, Johnston, Tatum, Underwood, Ullman, Coker, Bullitt and Dye. The secretary of the State Association was instructed to issue to the Madison County Society a duplicate charter, the original having been lost in transit. An executive committee of three, of which the chairman of the Council is ex-officio chairman, was appointed, with Ullman and Dye as the other two members, and instructed to work out the details of the medical defense and report same to the Council.

The Council recommends to the House of Delegates that it determine what is the fiscal year of the State and County Associations, and suggests that the year begin January the first. By a rising vote the Council expressed its thanks to the retiring chairman, Dr. D. J. Williams, for his untiring and valuable work for the past ten years. The press was granted permission to publish Dr. Sutherland's paper.

T. M. DYE,
Secretary.

J. B. BULLITT,
Chairman.

The secretary presented the following report:—

REPORT OF SECRETARY.

Jackson, Miss., April 8th. 1912.

To The House Of Delegates,
Mississippi State Medical Association:—

Gentlemen:—The establishment of our insurance bureau has brought up some questions, one, at least, of which should be considered by this body, at this time, lest misunderstanding should arise in the future:—

"What is our fiscal year?" In the absence of definite law on the subject your present secretary, when first entering office, followed the course of his predecessors in considering the calendar year the fiscal year. Most of the county societies have similar fiscal years but, as the county secretaries are not supposed to report to the state secretary until "ten days in advance of the annual meeting" it has been the custom to carry all members of one year on the roll until the first day of April of the year following, when the men who have not paid are dropped and the new ones added, the membership of the latter being dated back to January 1st., the object of this course being to be as lenient as possible in matters relating to membership. This plan has proved quite satisfactory but, under new conditions, should be officially approved by this body or set aside in favor of some other definite rule, so that there can be no mistake.

That the membership for 1912 will not equal that of the past three or four years seems to be an assured fact, though the falling off is much less than was at first anticipated. "Hard times and the boll-weevil" are given as the reason in some instances but the chief offender seems to be the increase in dues. Judging from the letters of inquiry received from numerous sources, many of the delinquents seem to be under the impression that they are not going to get anything extra for their extra dollar and write asking the reason for the raise. It would appear, therefore, that further education along these lines is needed.

The routine matters of the secretary's office have been arranged as exhibits, as heretofore, to facilitate their handling by committees.

Respectfully submitted,

E. F. HOWARD,

Secretary.

The treasurer being prevented from attending by the high-water conditions in the Delta, his report was read by the secretary, received and referred to an auditing committee consisting of Alexander of Tunica and Rape of Jackson:—

TREASURER'S REPORT.

To Mississippi Medical Association:—

At the 1911 meeting of this Association we had a balance in the treasury of $832.92, and on April 20th. 1911, our efficient secretary, Dr. E. F. Howard, sent me check for $1954.00, and on December 29th. 1911, I received another check for $63.00, making a total of $2849.92 handled by the treasurer.

The total disbursements since our 1911 meeting, to date, are $2039.37, leaving a balance in the treasury on this date of $810.55, which is shown in the Cotton Exchange Bank account.

Every voucher is numbered on upper left hand corner, and you will find the corresponding number on the left margin of the record page of

the ledger, date of payment following, to whom paid in center and the amount on right margin. The vouchers are not in numerical order on the ledger account, as I entered them in the order as received.

I herewith submit for inspection all pay-orders or drafts drawn on me by the secretary, with all bills for same, my bank book and ledger showing statement of my account with the Association funds.

Respectfully submitted,

L. B. SPARKMAN,

Treasurer.

Cleveland, Miss.,
April 6th, 1912.

Elliott of Marshall introduced the following amendment to the by-laws:

Add an additional chapter, to be known as Chapter XV, to read as follows: Chapter XV. The fiscal year of this Association and its component County Societies shall begin January first of each year.

Several communications from the American Medical Association and the New Hampshire Medical Society were read and referred to the Council.

The following nominating committee was chosen:—1st. district, Alexander of Tunica; 2nd. district, Elliott of Marshall; 3rd. district, Arnold of Choctaw; 4th. district, Grady of Monroe; 5th. district, Shepherd of Holmes; 8th. district, Seay of Lawrence; 9th. district, Catchings of Wilkinson; 10th. district, Ross of Forrest.

On motion of Councilor Johnston the House then adjourned and reconvened at 8:30 A. M., April 9th.

J. C. Culley of Hinds and Cooper of Newton were added to the nominating committee, representing the 6th. and 7th. districts.

Councilor Ullman addressed the House on the necessity of using care in the selection of councilors.

Coucilor Ullman offered an amendment to the amendment to the by-laws proposed at the previous session by Elliott of Marshall, to the effect that the fiscal year of the county societies begin not later than December first.

Councilor Dye offered the following amendment to the by-laws:—

Chapter VIII, section 5, line 4, following "legally registered physician who"; amend by changing remainder of sentence to read as follows: "does not practice sectarian medicine", etc.

The House then adjourned and reconvened at 8:30 A. M., April 10th.

Dr. W. S. Leathers presented the report of the committee on legislation:

Report of Committee on Legislation

At the request of the President, your committee on Public Policy and Legislation desires to make the following report:

There were three measures recommended by this Committee together with the Committee on Public Policy and Legislation of the State Board of Health and the Committee on Education. These committees had a joint session preceding the meeting of the legislature, and recommended for favorable consideration by that body a bill entitled the Medical Practice Act, a Vital Statistics Bill and also a bill carrying a larger appropriation for public health work. The members of these committees were persistent and aggressive in their efforts to obtain the passage of these bills during the recent legislature. The President of the State Medical Association performed a most faithful service in securing the co-operation of the physicians in behalf of this legislation. It is indeed gratifying to the Committee on Public Policy and Legislation to have recorded as a part of the business of the Association, the fact that every measure introduced by this Association during the last legislature was passed without any changes. The recent legislature looked upon medical legislation in a much more favorable way than heretofore, as is evidenced by the small minority vote against each bill.

We wish to express our profound appreciation for the invaluable services of Dr. S. W. Glass, chairman of the Committee on Public Health and Quarantine of the lower house, and of Dr. Kendrick, chairman of the Committee on Public Health and Quarantine of the Senate. These men were constantly active, persistent and aggressive in the interests of the Association, and in effecting such legislation as would benefit all the people. The medical profession was exceedingly fortunate in having as a part of this legislature a number of capable and loyal physicians, and we would deem it an unpardonable offense if we did not extend our gratitude and manifest a keen appreciation for the services which were also rendered by Doctors Conn, Crenshaw, Goodman, Ruffin, Crawford and Senators Donald, Broyles, Taylor and Rowan.

The success which was achieved during the recent legislature can only be attributed to the loyal and public spirited physicians of the state. We desire, therefore, to accord to you the credit which you have justly merited, and I am sure that every member of the committee feels

that what has been accomplished is a work of the physicians of Mississippi.

In conclusion I am sure that every member of the profession feels a sense of gratitude to the legislature for the magnanimous spirit which it has displayed in behalf of the medical profession in its efforts to conserve the welfare of the citizens of a great commonwealth.

Respectfully submitted,

Committee on Public Policy and Legislation
W. S. LEATHERS,
H. L. SUTHERLAND,
E. F. HOWARD,
DANIEL J. WILLIAMS.

Committee on Medical Education
D. W. JONES,
J. W. YOUNG,
J. W. GRAY.

Vote on the amendments to the by-laws being called, the amendment by Councilor Ullman to the amendment by Elliott of Marshall was defeated and the original amendment adopted.

The amendment by Councilor Dye was adopted.

Cooper of Newton offered the following resolution:

In view of the fact that the recent legislature acted in a most favorable way on the measures advocated by the State Medical Association, and because these measures were for the purpose of conserving the greatest of our natural resources, the health of our people,

Resolved, that the members of the State Medical Association, in session, desire to express in a public way their sincere appreciation and gratitude for the passage of the bills entitled the Medical Practice Act and Vital Statistics Act, and for the largely increased appropriation for public health work. We know that these laws will redound to the upbuilding of the citizenship of our state.

Ex-president Curry, in behalf of Councilor Ullman, offered the following resolution which was unanimously adopted:

Whereas the profoundest respect and highest admiration of all fair-minded people have been aroused by the earnest and efficient labors of Dr. Harvey P. Wiley, for the past several years in the campaign for pure drugs and pure food; and

Whereas the results of these labors have accrued to the great benefit of all the people of these United States; and

Whereas the opposition of selfish and ignorant interests has greatly hampered Dr. Wiley in his efforts and has finally forced his resignation;

Therefore be it resolved by the Mississippi State Medical Association that the secretary of this Association be directed to send to President Taft this resolution expressing respectfully our deep and genuine regret at the existence of such conditions as have rendered necessary the loss of so valuable a public servant as Dr. Wiley, and, further,

That, we respectfully urge, in the name of the medical profession of this state and in the interest of the whole people, that the conditions referred to above be so modified as to enable Dr. Wiley's successor to carry on without undue interference the great work that has been so nobly initiated.

President Williams addressed the House in behalf of the Southern Medical Association.

The House then adjourned and re-convened at 8:30 April 11th.

Roll-call showed the personnel of the House to be as follows:—President Williams; Councilors Dye, Eason, Underwood, Johnston and Wallace; Ex-Presidents Curry and Jones; Delegates Sessions of Adams, Kendrick of Alcorn, Shivers of Bolivar, Walker of Chickasaw, Arnold of Choctaw, Brown of Clay, Longino of Coahoma, Blount of Covington, Stevens of Forrest, Parker of Harrison, B. L. Culley of Hinds, Reed of Itawamba, Williams of Jefferson Davis, Boswell of Jones, Gaither of Lafayette, Hoye of Lauderdale, Spencer of Lee, Sandifer of Leflore, Spalding of Lowndes, Elliott of Marshall, Boyd of Monroe, Cooper of Newton, Hubbard of Noxubee, Dodds of Oktibbeha, Walley of Perry, Beacham of Pike, Haralson of Scott, Robinson of Simpson, Simpson of Sunflower, Clay of Tallahatchie, Payne of Washington, Catchings of Wilkinson, Spiva of Winston and Jackson of Yalobusha; Secretary Howard. During the session the following were added: Councilors Bullitt and Ullman; Delegates Allen of Attala and Shepherd of Holmes.

Councilor Dye, secretary of the Council, read a report as follows:—

REPORT OF COUNCIL.

The Council of the Mississippi State Medical Association met in K. of P. Hall, Jackson, at 9:30 P. M., April 8th. Present: Chairman Bullitt, Secretary Dye, Johnston, Coker, Ullman, Underwood. A charter was granted to the Lamar-Marion-Pearl River County Society, the Pearl River County Society having surrendered its charter.

A communication from the American Medical Association relative to a bureau of public speakers was referred to the General Session. One from the New Hampshire State Medical Society regarding reciprocity

was considered and the following resolution ordered sent to the House of Delegates:

Resolved that the State Secretary be instructed to notify the New Hampshire State Medical Society that the physicians of Mississippi generally favor reciprocity, with certain necessary restrictions to be determined by our State Board Of Health.

Replying to a query from the State Secretary, the Council rules that a member expelled from a local society shall be held as expelled from the State Association until he shall have been readmitted to the same or some other component society.

Replying to a query from the State Secretary the Council rules that Chapter XIII, Section 9 of the by-laws confers on such members full membership privileges.

A duplicate charter was granted the Clarksdale And Six Counties Medical Society, the original having been lost.

The executive committee appointed at the 1911 meeting reported that it held a meeting in Jackson, May 9th. 1911, and discussed plans for medical defense.

Council met at 9:45 A. M., April 10th. A request was made by the councilor of the sixth district that a charter be granted to Hinds and Rankin Counties for a bi-county society to be known as the Central Mississippi Society. This councilor reports that both the Hinds and Rankin charters are lost. The State Secretary is authorized to grant the charter requested upon receipt of official petition from the officers of the present societies of said counties.

Certain matters regarding newspaper advertisements of Dr. Julius Crisler of Jackson have been brought to the attention of the Council. All the testimony brought tended to show that Dr. Crisler had no personal knowledge of these matters and was guilty only of carelessness and indiscretion in not taking due precautions to prevent such publications.

Information has been brought to the Council that a suit for malpractice has been recently filed, January 1912, against Dr. T. F. Willson of Washington County, for participation in an operation performed on or about April 10th. 1911, and resulting in alleged injuries to the plaintiff. Since the occurrence for which this suit was brought took place prior to the commencement of the fiscal year of 1912, and hence prior to the date at which our medico-legal defense plan came into effect, the Council feels that it has no legal nor moral right, under our law, to undertake the defense of this suit. But as some of Dr. Willson's friends, including one of the councilors, insists that this defense should be undertaken by us, we present to the House of Delegates this request for advice as to whether or not we can take charge of this case.

J. B. BULLITT,
Chairman.

T. M. DYE,
Secretary.

Councilor Johnston entered a minority report as follows:

The House of Delegates is requested to advise the Council that it has a legal right to undertake the defense of Dr. T. F. Willson of Washington County.

S. W. JOHNSTON,
Councilor Sixth District.

On motion of Ex-President Curry the report of the Council was considered by sections, with the result that the report was received and approved and the minority report of Councilor Johnston rejected and the request that the bi-county society composed of Hinds and Rankin be allowed to assume the name the Central Mississippi Society was refused. The secretary was instructed to issue this charter to the Hinds-Rankin County Medical Society, subject to the provisions made by the Council.

Reports of the auditing committee were read and approved:

April 10th. 1912.

To the House of Delegates Mississippi State Medical Association:—

Your committee begs to report that our examination of the Secretary's books shows that dues to the amount of $2,024.00 were collected for 1911, $7.00 of which was returned to County Societies as over-paid dues, and the balance $1,954.00 being remitted to the Treasurer all of which transactions are covered by vouchers, and correspond with showing of Treasurer's books.

We have examined the following bills, which are approved by the proper authorities or covered by vouchers, and we recommend they be paid:

To the Mississippi Printing Co., for stationery, printing etc	$ 96.54
To the Secretary for Postage, Telephone Messages, etc	32.62
To Dr. T. M. Dye, Councilor Expenses	5.00
To Dr. S. W. Johnston, Councilor Expenses	15.50
To Dr. F. J. Underwood, Councilor Expenses	28.85
To Dr. J. S. Ullman, Councilor Expenses State Board of Health,	11.00
To Dr. S. E. Eason, Councilor Expenses	9.50
To V. Otis Robinson, Services in Legislation	200.00
	$399.01

Respectfully submitted by,
M. J. ALEXANDER,
J. N. RAPE,
Auditing Committee.

April 10th. 1912.

To the House of Delegates, Mississippi State Medical Association:—

Your auditing committee begs leave to report that we have examined the Treasurer's books and find they show a total of receipts up to April 6th. 1912 of $2,017.00 which with a balance of $832.92 brought forward from last report makes a grand total of $2,849.92. The total disbursements for the same period was $2,039.37, leaving a balance now on hand of $810.55, said balance bring in the Cotton Exchange Bank, Cleveland, Miss.

Disbursements are all covered by proper vouchers.

Respectfully submitted by,

M. J. ALEXANDER,
J. N. RAPE,
Auditing Committee.

Ex-President Curry offered the following resolution, which was adopted:

Resolved, that it is the sense of this House of Delegates that the medico-legal law shall be repealed.

The secretary was instructed, on request of Councilor Ullman, to insert a note to the effect that the passage of this resolution in no manner repealed the law, such a step being impossible at this time, but is merely an expression of opinion of this House.

Councilor Bullitt offered the following amendments to the Constitution:

Amend to read as follows:

"Article VI, Section 1. The officers of this Association shall be a President, a President-elect, three Vice-Presidents, a Secretary, a Treasurer and ten Councilors.

Section 2. The President shall serve for one year. The President-elect shall serve for one year and shall serve as President for the next succeeding year." The remainder of the Article to read as at present.

Amend Article VII by adding the words "the President-elect" after the word "President."

The nominating committee presented the following report:—

REPORT OF NOMINATING COMMITTEE.

Jackson, Miss., April 11th. 1912

To The Council and House Of Delegates:—

Gentlemen: We, the nominating committee, beg leave to submitt the following nominees:

For president: S. W. Glass, Dublin; L. C. Feemster, Nettleton; W. D. Arnold, Ackerman.

For vice-president: J. C. Walker, Houlka; W. W. Parks, Louisville; E. C. Parker, Gulfport.
For councilor 7th. district: S. A. Majure, Dixon.
Four councilor 8th. district: G. W. Wallace, Arbo.
For delegate to A. M. A.: D. J. Williams, Gulfport.
For alternate delegate to A. M. A.: J. T. Longino, Jonestown.

Respectfully submitted,
For the Committee,
B. A. SHEPHERD, Chairman.

Dr. L. C. Feemster of Nettleton asked to be heard by the House and being accorded the courtesies requested that his name be withdrawn and, with the consent of Dr. Arnold, that the secretary be instructed to cast the vote of the House for Dr. Glass. Dr. Feemster stated that he was by no means unappreciative of the honor done him but that Dr. Glass, by his services to the Association during the recent session of the legislature, had earned the support and consideration of all loyal members, among whom he himself was proud to be enrolled. Dr. Arnold heartly seconding Dr. Feemster's remarks, the secretary was instructed and cast the ballot accordingly.

Ex-President Curry and Delegate Longino of Coahoma expressed for Dr. Glass their appreciation of the courtesy of Drs. Feemster and Arnold.

The secretary, by instruction of the House, cast the ballot for the remainder of the nominees.

Consideration of the place for next meeting being taken up, Councilor Johnston invited the Association to Vicksburg, Delegate Parker of Harrison presented several letters of invitation from officials of Gulfport and from the Harrison County Medical Society, and Councilor Dye placed Jackson in nomination.

On the first ballot Jackson received the smallest number of votes and was dropped, and on the second Vicksburg was chosen.

After reading and approval of minutes the House then adjourned *sine die*..

E. F. HOWARD,
Secretary.

D. J. WILLIAMS,
President.

REORGANIZATION MEETING OF COUNCIL.

Jackson, Miss.

The Council met at eleven a. m., April the eleventh, following the adjournment of the House of Delegates, and reorganized by re-electing the former Chairman and Secretary and retaining the same Executive Committee as last year. The Press was granted the privilege of publishing the paper of Professor E. M. Ranck. Present: Bullitt, Ullman, Eason, Wallace and Dye.

T. M. DYE,
Secretary.

J. B. BULLITT,
Chairman.

CHAIRMEN OF SECTIONS.

Hygiene	M. J. Alexander	Tunica
Surgery	J. G. Gaither	Oxford
Eye, Ear, Nose and Throat	W. L. Howard	Greenville
Medicine	P. Beekman	Natchez
Physiology, Pathology and Bacteriology	T. G. Hughes	Clarksdale
Obstetrics and Gynecology	L. C. Feemster	Nettleton
Materia Medica	R. H. Foster	Meridian
Pediatrics	L. D. Dickerson	McComb

Society Proceedings.

East Mississippi Four County Medical Society met at Tupelo April 16th. In the absence of Drs. Reid and Underwood, Drs. Farrar and Gurney served as president and secretary. No papers were read but Dr. Bryan reported an interesting case of lymphatic leukemia. Drs. Gurney, Farrar and Bonner also presented case reports. Present: Drs. Bryan, Boggan, Wicks, Bonner, Elkin, Gurney, Feemster, Farrar. Visitor : Dr. Hunter of Greenwood.

J. O. GURNEY.

Mississippi State Medical Association.

OFFICERS.

PRESIDENT.

S. W. GLASS.....Dublin

VICE-PRESIDENTS.

J. C. Walker.....Houlka
W. W. PARKS.....Louisville
E. C. PARKER.....Gulfport

SECRETARY.

E. F. HOWARD.....Vicksburg

TREASURER.

L. B. SPARKMAN.....Cleveland

STANDING COMMITTEES.

COMMITTEE ON PUBLIC POLICY AND LEGISLATION.

H. L. Sutherland, Benoit; W. S. Leathers, University; F. M. Sandifer, Greenwood; S. W. Glass, Dublin; E. F. Howard, Vicksburg.

COMMITTEE ON MEDICAL EDUCATION.

D. W. Jones, Brookhaven; J. W. Young, Grenada; D. J. Williams, Gulfport.

COMMITTEE ON PUBLICATION.

E. F. Howard, Vicksburg; D. W. Coker, Tunica; H. F. Sproles Jr., Vicksburg.

COMMITTEE ON SCIENTIFIC WORK.

E. F. Howard, Vicksburg; W. D. McCalip, Yazoo City; S. Myers, Vicksburg.

DELEGATES TO AMERICAN MEDICAL ASSOCIATION

J. W. Young, Grenada; alternate C. D. Mitchell, Pontotoc.
D. J. Williams, Gulfport; alternate J. T. Longino, Jonestown.

MISSISSIPPI MEDICAL MONTHLY.

E. F. HOWARD B.S., M.D., Editor and Publisher.

S. MYERS M.D., Business Manager.

ASSOCIATE EDITORS

F. J. UNDERWOOD, M D., Nettleton. H. L. SUTHERLAND M.D., Benoit.
H. M. FOLKES M.D., Biloxi. M. H. BELL M.D., Vicksburg.

OFFICIAL ORGAN OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION AND ITS COMPONENT SOCIETIES.

SUBSCRIPTION ONE DOLLAR PER ANNUM.

The 1912 meeting of the Mississippi State Medical Association has gone into history as one of the most successful yet held by that body. The attendance was not quite up to the average of recent years, due to the absence of our Delta brethren, in whose subsequent troubles we heartily sympathize, but we made up in enthusiasm what we lacked in numbers and all agreed that we had "one more time."

We were naturally in a good humor because we had to celebrate the success with the recent legislature and we had an excellent bill-of-fare in the shape of a program that fairly bristled with good papers. What more could anyone ask, and we are noted for making the most of everything.

It was all so good that it is hard to pick out any one special event in the scientific program, but in the executive sessions there was one that stands head and shoulders above everything that has happened on the floor of the Association in the past ten years: Dr. Feemster's exceedingly graceful refusal to contest the election for the presidency with Dr. Glass. It is noted in the minutes of the House of Delegates, that will be found on another page of this issue, but the official language of the minutes gives no real idea of the condition of affairs. When Drs. Reynolds and Elliott pulled out last year to make way for Dr. Williams, it was generally conceded that it was graceful thing to do but that Dr. Williams would probably have won on the first ballot anyway. This year it was different. Dr. Glass had fairly won the place by his magnificent service in the legislature but Dr. Feemster would have made a glorious race. Between two such men it is always

"nip and tuck" on anything they do and either would have been an honor to the Association. Dr. Feemster's withdrawal was from no apprehension that he would be defeated; he knew he had too many close and good friends in the House to fear that he would not have a hearty support, he knew that the absence of so many men from the Delta weakened Dr. Glass' probabilities, and he is too big a man to fear an honest, clean defeat at the hands of a man like Dr. Glass; his withdrawal was the courteous, gracious act of a gallant gentleman who saw that this was the one time of all others when the election would do most honor to Dr. Glass and wanted to make that honor as signal and marked as possible. The Association should be proud that it has honored Dr. Glass for the masterly manner in which he conducted the legislative fight; it should be equally proud that it has such material in store as Dr. Feemster out of which to make a president in the future.

Book Reviews.

OPHTHALMIC MYOLOGY By G. C. Savage, M. D., Professor of Ophthalmology, Medical Department of Vanderbilt University, etc. Second edition. Published by the author, 137 Eighth Avenue North, Nashville, Tenn.

The author takes issue with the teaching of Helmholtz, which has been almost universally followed by the scientific world, and says the difference between them hinges on the correct answers to the following questions:

(1) Is the center of the cornea always the anterior pole? (2) Is the central point of the macula always the posterior pole of the eye? (3) Do all secondary visual lines cross the visual axis at the nodal point? (4) Do all secondary visual lines cross the visual axis at the center of retinal curvature—the center of rotation? To (1) Helmholtz answers yes, Savage no; (2) Helmholtz no, Savage yes; (3) Helmholtz yes; Savage no; (4) Helmholtz no, Savage yes. The first 145 pages give the author's arguments in support of his teaching and the phisiologic aspect of the subject as presented by him is a very complex study, mastery of which is greatly aided by the muscle indicator elaborated by the author for the purpose of showing all possible conditions of the ocular muscles.

After a clear comprehension of the fundamental principles laid down in the first chapter the mastery of the practical part of the work is easy.

A consideration of the various phorias and tropias covering about 520 pages completes this very meritorious work.

The book deserves special credit as it is all original and represents many years hard work on the part of the author and while some may not agree with all his teachings he is confident the scientific world will accept as true the principles here set forth.

A careful study of the volume will well repay any one and especially those doing eye work.

M. H. BELL.

MISSISSIPPI MEDICAL MONTHLY

VOL. XVII. JUNE 1912. NO. 2.

*THE REBATE EVIL IN THE MEDICAL PROFESSION.

A. G. EVERETT M.D.,

FRIARS POINT.

Gentlemen and Members of The Clarksdale and Six-Counties Medical Society:—

In presenting these few scattering remarks I want to ask your indulgence, for a short time only, along a line of thought that I have considered for a number of years, how best to remove one of the chief causes of petty jealousies of the medical profession in the several communities—rebating the planters or employers of large numbers of laborers.

I will first ask why should we, as a profession, be required by custom to surrender at least one-tenth of our earnings to the landlords or employers for the privilege of looking after the sick and afflicted, while we are toiling day and night trying to make an honest living for ourselves and families? Whence came this ancient practice of paying tribute to Caesar? Does this custom prevail throughout our state and the entire Southland, or is it confined to what is commonly known as the "Black Belt?"

In answer to these questions, I will have to say I don't know. Rebating may have had its origin with the pioneers of medicine, but I had rather believe it had its birth along with modern commercialism. Charlatans and quacks may have instituted it, knowing their services were dear at any price, and by their aggressiveness literally forced the regular physician into the practice of giving bribes for business.

Did you ever stop and think of the handsome amount the medical profession, in our Six-Counties alone, is annually filched of, or in other words is helping to rob the tenants and employees of? Taking two hundred as the number of physicians in our Six-Counties as the basis, and putting each physician's contract, or plantation practice, at one thousand dollars,

*President's address before the Clarksdale and Six-Counties Medical Society.

only, and we have each physician contributing one hundred dollars annually; multiplying by two hundred gives us the sum total of twenty thousand dollars, tribute, which I dare say is not one-half our Six-Counties gives to satisfy the greet of the moneyed interest where none is due.

I say none is due because the planters, or others, add their laborers' doctor-bill to their other accounts and charge the same rate of interest as though they had furnished money or merchandise. The tenant does not get the benefit of the rebate. Some physician may say, "Oh! very well, we get good prices for our services, and can afford to give ten, fifteen, twenty or even twenty-five per cent. discount." My reply to reasoning of that kind is to lower the fees and not continue a partner in a grafting scheme, especially when it robs the poor and afflicted. I contend that the medical profession is by far the poorest paid of any profession in the entire world to-day, compared to what it has done and is doing for humanity. Then let us awake and assert our rights for rights' sake, and not continue longer in the practice of taking from the poor and giving to the well-to-do, while going about on missions of mercy, administering to the sick and afflicted.

If we would stop the practice of discounting our bills we then would have eliminated the principle cause of all the so-called professional jealousies in our several communities. Some may contend that we have a regular scale of discounts and every physician abides by that schedule. That I deny and can prove to anyone who may doubt what I say. The rule I have found that works surest is that the wealthier the planter, the larger the discounts demanded. Right at this point I want to relate a little of my personal experience. When I came to Delta, I located at a very small town, a one-doctor town as we call them. I was told by the business men there that I would be expected to give ten per cent. discount off of all fees the merchants or planters guaranteed payment of, which I did, but on moving to my present location the first call I got through a planter, he hailed me on my way out and requested that I charge his tenants sufficient that I could give him twenty per cent. off, and I learned later that this self-same Christian gentleman only added twenty per cent. to all bills, giving him a straight forty per cent. on every dollar paid out. I am sorry to have to confess that I submitted to help perpetrate this scheme of robing for nearly two years, since which time I have given ten per cent. to all alike, and that I am more than anx-

ions to quit giving this amount of tribute I will prove to all if I can get the cooperation of the members of this society. Some will say "We cannot quit giving rebates; if we do the employer will quit guaranteeing payment of fees." This I deny. I believe most people want to do right, and when you show, by proper explanation, the employer where he is asking you for a bribe, for such it truly is, by explaining to him that you know he gets a good rate of interest on money he pays you, all honest ones will see that you are right and accept it as final, and others must.

As the system of rebating now stands, there is no set rule as to the amount of discount to allow planters or others; consequently one physician may be doing practice on a plantation and giving only ten per cent. when suddenly he realizes he has been supplanted by his colleague, and later learns that his worthy colleague is paying a larger bribe, is all the fault that was found with his services; all which gives rise to all sorts of rebates, varying from ten to twenty-five per cent., hence the bickerings and petty jealousies. The above conditions, every physician who has practiced in the Delta five years or more knows to be true. Then why longer tolerate it? Is it because of the fear of the finger of scorn that might be pointed at us for past sins? If so remember it is never too late to correct a mistake in morals.

The legal profession, heretofore, has poked fun at the medical profession about its fee-splitting practices, but of late years the lawyers have had troubles of their own, in other words "The ducks have come to roost" and to-day the legal profession as well as the medical profession is wrestling to rid itself of that class of jugglers of human destinies.

I noticed in a recent number of one of our medical journals that the New York Academy of Medicine has passed resolutions to expel any one of its members guilty of "fee splitting." Will some astute logician explain to us the difference in principle of the fee splitter and the man accepting the rebates; and also tell us the difference between the city doctor who divides or splits his fee with his colleague, and the country doctor who divides or splits his fees with the planter. If the latter is right, the other is harmless. If one is wrong, the other is not right.

I do not at this date recommend such drastic measures as expulsion from society privileges for rebating or giving discounts, but I do think this society, as it is the largest county

society in the state, ought to take some steps to stop this nefarious practice of rebating. The least we could do would be to appoint a committee, consisting of one member from each county, whose duties it would be to investigate the rebating practices in the several communities and report back to this society at its next regular meeting, with suggestions and plans for regulating or prohibiting the custom of discounting fees by its members.

The highest courts of our country have said rebating is illegal, and we all know it is morally wrong to take from the weak and give to the strong; then, gentlemen, why longer submit to the unholy and greedy demands of Mammon, and give at least one day's earnings of every ten, and I know planters that demand one day of every five, to the money god.

We abuse and heap all kinds of epithets upon John D. Morgan and the Rothschilds, for their high-handed methods of oppression and greed, but here we are, in the sparsely settled sections of the country where high ideals are not only born but expected to develop, silently submitting to a partnership with the landlords and employers in their scheme of robbing their vassals.

I think if the Clarksdale and Six-Counties Medical Society will take the lead in stamping out this evil, as we can look with pride upon other things accomplished by a united front from this society, we will have done ourselves great service and more especially humanity, and humanity is, after all, what the true physician strives to serve.

SOME PRACTICAL PRINCIPLES OF SUGGESTION.

S. T. RUCKER M.D.,

MEMPHIS, TENN.

"A merry heart doeth good like a medicine,
But a broken spirit drieth the bones."

This psychological law is as true to-day as when first proclaimed by the writer of the proverbs three thousand years ago.

It is a fact of common knowledge, which is confirmed by the experience of laymen, as well as physicians and psychologists, that certain morbid states of the mind are accompanied

by various derangements of the functions of the body. By morbid states I mean the character of certain thoughts one may harbor and permit to cloud the sphere of consciousness, producing illogical doubts, fears, anxieties, beliefs in fictitious disease, emotions of anger, jealousy, hatred and revenge.

Such conditions of mind are so many malignant forces within us, poisoning the blood, exhausting nerve force and inhibiting functional activity of vital organs.

We sometimes see the power of thought, of this character, strikingly illustrated when psychic emotions incident to a great sorrow, disappointment or reverse, in a short time so changes the personal appearance of a man that his friends scarcely recognize him and his vital forces are so depreciated that he is unfitted for business or social duties.

It was not the thing that happened that was so destructive to hopes, happiness and health, but morbid re-actions in the psychic centers. A destructive hurricane of thoughts refusing to be calmed or reconciled. Furthermore, in certain persons, the modes of mental activity I have described, when permitted to continue, produce various nervous diseases, such as neurasthenia, hysteria, psychasthenia and phobias of various kinds, which are often accompanied by disturbance of visceral function.

Physiological and clinical observation have shown that psychic trauma, or emotional storms will alter the rhythm and rapidity of the respiration and heart's action, contract the arterioles, increase the function of the sweat glands, inhibit peristalsis, check salivary and gastric secretion, decrease muscular energy and awaken the sense and symptoms of fatigue. This being true one can readily understand how the health may be seriously impaired by the character of thoughts that possess the mind.

Per contra, it is a fact, accepted as proven, that when healthy mental states are substituted for unhealthy ones of the character I have described, the functional derangements of the body tend to disappear. Thoughts of joy, good cheer, hope, faith and other pleasurable emotions, often alter in a marked degree the various visceral functions. The heart's action is increased, blood pressure is regulated through the vaso-motor system, an abundance of the digestive juices are poured out, muscular energy is increased and a feeling of well-being is created. He who is strong enough to persistently

hold in mind this kind of thoughts will have peace, joy, health and happiness. A cheerful, optimistic and positive mental attitude, associated with bodily health, is the best preventive medicine. It maintains an active vitality and a strong resistance against the invasion of disease.

Someone has aptly said that "we cannot prevent a bird from flying over our heads, but can keep it from building a nest in our hair." Neither can we prevent undesirable persons from knocking at the doors of our homes, but we can refuse them admittance.

So the mind can be trained, by suggestion, to choose and entertain the kind of thoughts desired and reject all opposing thoughts. By suggestion I mean "the power an idea has in our mind to suppress another idea." We call it autosuggestion when the will chooses such ideas as are desired and holds them in mind to the exclusion of all others.

As physicians we do much to relieve suffering, heal disease and promote the health and happiness of patrons: we could accomplish more in this direction if we would recognize the "psychology of suggestion" and utilize the normal mechanism of the mind to influence the physiological machinery of the body.

Suggestion cannot create anything that is new, nor do anything that is not in accord with the laws of the nervous system: it can only make use of the machinery already provided. By suggestion a healthy psychic complex can be organized and substituted for unhealthy ones and perverted function corrected.

Erratic ideas, wrong beliefs and habits of thought can be changed and dissipated by psycho-analysis and the introduction of new data previously known to the patient and drawn from the wider experience of the physician. New ideas and mental complexes can be artfully created and substituted for old ones.

To be effective new ideas must be based on facts and reason and fixed in the mind by positive suggestions, else they become the sport of every passing thought and feeling. In selected cases it is a good plan for the physician to introduce new ideas and data, and teach the patient how to go over and repeat them (auto-suggestion) until the old ones fade away and disappear.

All nervous diseases, such as neurasthenia, hysteria, psychasthenia, the various phobias and some psychoses are amenable to treatment by suggestion. All curable organic diseases

can be favorably influenced by suggestion properly given. All physicians, consciously or unconsciously, use some suggestion in their daily practice and as all persons are more or less susceptible to suggestion this is a factor that should be reckoned with. A physician with a wise experience and confident air suggests ability to relieve suffering and heal disease. It is a well known fact among laymen that patients feel better as soon as the physician enters the sick chamber. The giving of medicines suggests to the patient that certain benefits will result. As a rule a remedy will be more potent if the patient is told to expect a certain result.

The physician who does not know that suggestion is a factor in the practice of medicine is handicapped by denying himself the use of a most valuable adjunct to other therapeutic procedures.

The successful application of suggestion is not a simple procedure, but an art acquired by diligent study and constant use of the principles above formulated. It requires all the skill which comes from a knowledge of human nature, of life and the intricate workings of the mind: and some conception of what Christ meant when he said "thy faith hath made thee whole."

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*TREATMENT OF ECLAMPSIA.

S. E. FRIERSON M.D.,

LYON.

Treatment of this grave malady from a strictly idealistic viewpoint, means prophylaxis. This involves routine, systematic, persistent urinalysis; strict, hygienic precautions embracing diet, exercise, fresh air and a careful regard for the eliminating organs; keeping them sufficiently active to insure against auto-intoxication, which no doubt is the etiological factor in every case of eclampsia, whether it be from the bowels, kidneys, placenta or what not.

Davis and Edgar say that eclampsia is always a preventable affection. Williams says "such a satisfactory condition of affairs can hardly obtain until its aetiology is perfectly understood and we are in possession of more accurate and reliable methods of foretelling the outcome in cases of pre-eclamptic

*Read before the Clarksdale and Six Counties Medical Society.

toxemia." However that may be, let that physician who neglects to observe the rules laid down as a guide in the care of such cases, given into his keeping during gestation, take unto himself the charge of criminal neglect.

Yet in spite of the fact that these cases are largely preventable, they sometimes occur. They are occasionally seen, too, where most rigid care is taken by the physician in charge to prevent them. Most cases of eclampsia occur among the ignorant, who know nothing of the importance of a physician's care in such cases, and it is with especial reference to these cases that this paper is addressed, rather than to those cases that may be prevented by proper prophylaxis.

Being called recently to a case that had been in a state of clonic convulsions for eight hours, I gave as an initial dose one tenth grain of apomorphine. After half an hour, fifteen minims of veratrum viride hypodermically were given and in thirty minutes more this dose was repeated. In an hour from this time ten minims more were given. In about three hours her pulse rate was reduced from one hundred and twenty to fifty-eight per minute. During this time eliminating agents were administered *ad libitum*. Upon examination the os was found soft and slightly patulous. The question that arose in my mind, and one over which I have thought much since, was whether this woman should be delivered immediately or whether she should be rid of her toxemia and allowed to carry her child until nature would intercede. I hesitated at first and had I the case in hand now I would hesitate some more. It is a well known fact that during pregnancy all organs do an increased amount of work and that the volume and cellular elements of the blood are increased. Many of the white cells are destroyed in the placenta, which gives rise to fibrinogen and fibrin ferment. This ferment circulates in the blood and its deleterious effects are felt in the liver and capillaries, especially of the kidneys. Inability of the liver to synthesize the globulins results in eclampsia. Going on this theory then we readily see the urgent necessity of immediate delivery. Statistics that I gather from literature show about sixty-five per cent. of these cases do not have convulsions after delivery. The modern conclusion is to deliver immediately, as soon as the first convulsion occurs. The convulsions in the above mentioned case showing a disposition to return whenever the effects of the veratrum ceased, decided to deliver. Without a great deal of difficulty the os was dilated manually and the child

delivered with instruments. The woman went immediately into profound shock. Her extremities were cold and pulseless. Stimulants were given and heat applied and after several hours she revived; when she did the convulsions returned. More veratrum was given and at this point bleeding was instituted, saline infusions given and elimination encouraged by sweating and the usual purgatives. The patient soon went off into coma from which she has not yet awakened.

Accouchment *a force* adds a violent source of irritation to the already overwrought nervous system, and whether it would be better to take a little more time and allow nature to empty the uterus, thereby obtaining delivery with minimum shock, at the same time endeavoring to rid the patient of toxines by elimination, or deliver at once regardless of shock, is a question over which there is some dispute.

From a very limited experience it would seem that if convulsions can be controlled by methods working towards, or at least not interfering with, the free elimination of toxines, it would be better to wait until the os is dilated sufficiently to apply forceps or perform version. Such methods as are included in the above statement are the administration of apomorphine, veratrum viride, chloral hydrate, salines by infusion and injection and venesection, together with active stimulation of the emunctories. The action of such drugs as chloroform and morphine, while producing a most happy immediate effect, have their serious objections which we will take up a little later.

Apomorphine stimulates the secretions of the lachrymal, salivary and nasal glands, also the bronchial mucous membrane. It possibly has the same effect on the mucous membrane throughout the alimentary tract, thus favoring elimination. On the nervous system it acts as a hypnotic. It relaxes the entire muscular system and in a measure controls convulsions, and would seem to be a very good initial dose in eclampsia. Care should be taken not to give it in doses sufficiently large or often enough repeated to get the depressing effects. One dose is as much as I have ever given to one patient. If it is to be repeated the dose should be small.

Veratrum viride is regarded by many as a most reliable remedy to control the convulsions of eclampsia. It may be stated that when the pulse is reduced to sixty or below, no convulsions will occur. It is credited with being depressing to the heart, but in eclampsia it has been given in very large

doses without untoward results. It is followed by no unpleasant after effects and deserves a place of first mention in the treatment of eclampsia.

Cloral hydrate as an adjuvant to other drugs has a place in the treatment of this disease also. Its action is more hypnotic and less anaesthetic than chloroform. Given in doses of one-half to one dram by rectum, its benefits in conjunction with other drugs is well recognized by those who have used it.

Phlebotomy, vigorously practiced a number of years ago, lost, for a while, its favor among the profession but has been restored somewhat in more recent years. However there are still those who regard it as one of the relics of barbarism. I would not hesitate to use it in the treatment of any case where the pulse was full and bounding. Williams says "Personally I have bled with most excellent results a number of patients whose pulse was thin and weak. This experience would certainly seem to show that venesection is indicated in all cases in which delivery is not followed by a cessation of the convulsions, not matter what the condition of the pulse." If bleeding is to be performed, to obtain the best results, it should be done early or at least before edema of the lungs and cyanosis set in and carried to the point of reducing the volume and tension of the pulse to a very perceptible degree.

Saline infusions deserve especial mention just here. They dilute toxines and stimulate the kidneys and are especially indicated if phlebotomy is performed.

To aid elimination of toxines by diaphoresis, there is no better method than wrapping the patient in blankets wrung out of hot water, covering with dry blankets and placing hot-water bottles around the patient.

Decapsulation of the kidney has been done with some degree of success, but such a capital operation as that or Caesarian section for eclamsia is without the scope of this paper as well as beyond the skill of this writer.

Chloroform and morphine, while producing a most happy immediate effect, have their serious objections. Many authorities advise that in the presence of actual eclampsia, chloroform should be administered during the convulsive attacks in the hope of cutting them short, after which morphine should be given until relief is obtained. Perhaps a little chloroform is better than several convulsions, while waiting for other methods to get the patient under control, but let us bear these facts in mind about the two drugs mentioned: pregnancy

exerts a deleterious influence on the liver cells; the extra burden of eliminating the excreta of the foetus from the mother produces certain changes in the liver; when these cells are unable to function properly the patient suffers from pernicious, vomiting, eclampsia or acute yellow atrophy; the changes produced by these conditions are nearly identical with those due to chloroform poisoning. Chloroform at the time of labor tends to increase those pathological changes, *i.e.* fatty degeneration and necrosis of the liver, heart, kidneys and muscles generally, that, when sufficiently pronounced, lead to the post-mortem picture of eclampsia. Chloroform is changed into an irritant poison in the liver and if the cells are unable to synthesize them they are in turn acted on by these products and undergo fatty degeneration and necrosis.

Ether should be used except in cases of acute yellow atrophy, when an anesthetic is needed, instead of chloroform. Its action is as positive and its dangers less.

Morphine quiets the nervous system but unfortunately for such conditions locks up secretions, which favors the retention of the damaging agents in the blood. It is eliminated very slowly, chiefly through the kidneys, having been detected in the urine three days after its ingestion, and even as long as seven days in habitual users of it when suddenly stopping.

All remedies held by those of experience may be good and may meet with success, but let us not forget the adage "he who purges well, treats well." Looking to permanent relief, vigorous purgation must be instituted. For this calomel is king, but should be aided by magnesium sulphate, castor oil, croton oil and high enemas.

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*SURGERY OF THE EYEBALL FOR THE PRESERVATION AND RESTORATION OF THE SIGHT.

A. C. LEWIS M.D.,

MEMPHIS, TENN.

The honor bestowed upon me by the East Mississippi Four County Medical Society, in inviting me to present a paper before it, is highly appreciated. In proof of this I am not going to bore you with a long-winded discourse on some disease of the eye, ear, nose or throat in which the general practitioner is little interested, or the minute details of any surgical opera-

*Read before the East Mississippi Four County Medical Society.

tion upon the eye that would be of no service to you. I am going to give you a brief description of ocular diseases and conditions frequently encountered by the oculist, in which the vision can be preserved or restored by surgical interference.

These conditions are squint, cataract, glaucoma and opacity of the cornea.

Squint, usually called "crosseye" or "cock-eye" is an extremely common condition, and it seems to be more common in this locality than in any I ever lived, either in this country or in Europe. This, in my opinion, is not due to any peculiarity of the people or of the climate, but to the fact that few of our local oculists are sufficiently interested in the muscular anomalies of the eyes to insist upon their correction. Having confidence in one's own ability, it is not usually difficult to convince the patient that his eye should be straigtened and that it can be quickly done without danger, either to him or to the eye itself.

The "crosseyed" man or woman is greatly handicapped in the race of life. This is due more to the deformity present than to the fact that they have but one useful eye. When both eyes are used in this condition all objects appear double and to avoid this the mind quickly learns to suppress the image formed in the squinting eye, in consequence of which its vision diminishes rapidly.

The time to correct squint is as soon as possible after its appearance, which is usually in early childhood. Then it can generally be done without operation by the prescribing of suitable glasses. Most of the internal squints, eyes turned toward the nose, are caused by far-sightedness and the external, turned-out variety by a near-sighted condition.

It is customary to wait until a child is seven years old before either operating for squint or prescribing glasses to remove the cause of it. As a rule it is best to wait until that age before operating, but not for correcting the refractive error with suitable lenses. This should be done just as soon as the child is old enough to be persuaded, or compelled, to wear them; if this were done most of them would never need the operation. In order to prevent the weakness of vision in the "crosseye" caused by non-use in these children while they are too young for operation, I use atropine at regular intervals in the straight eye so that they must use the squinting one for all near objects. This sometimes corrects the squint too in a most unexpected manner.

I can recall four cases of marked squint in children between the ages of four and six years I have treated this year with atropine and glasses, in which the eyes are now perfectly straight. They will never have to be operated upon as would have been the case had I waited until the age of seven was passed. Of course I am cheating myself out of operations, and fees too, but none of us merit any praise for doing our duty.

Internal squint in older children can often be corrected by a simple tenotomy of the internal rectus muscle of the squinting eye, and I have straigtened a number in this manner. There is some danger however of getting an over-correction later from tenotomy, and the safest method is to shorten the long muscle first and then do a partial or total tenotomy on the opposite muscle if necessary. Many different methods are employed to shorten these muscles. I use the resection operation of Reese, in which as much of the tendon as necessary is excised and the muscle reattached at its old insertion, and find it both simple and effective.

While most crosseyes can be corrected without much trouble this is not true of congenital and paralytic squint, nor where the vertical and oblique muscles are at fault; these however are not so frequent.

I will report a case of external squint I operated on last month for cosmetic purposes with a very gratifying result:— Miss B., aged twenty-two, a pretty brunette except for a bad eye, came to me on September 14th, 1911. Patient said she had a cataract on her left eye, which proved to be a thick, white, corneal opacity about one-fifth of an inch in diameter, from an old ulcer which had perforated and healed with an incarceration of the iris. The eye was practically sightless and turned out about fifteen degrees. She was so sensitive about its appearance that it was almost impossible to get her to look one in the face. Under cocaine anesthesia I tattooed the white corneal scar with black India ink and repeated it once a week for four weeks. At the end of that time the scar was no longer visible and on November 2nd. I did a resection on the left internal rectus muscle with satisfactory result. November 4th., finding slight deviation still present, I tenotomized the left external rectus. She was in to see me last week with both eyes apparently straight, holding her head up, a beautiful girl and no longer a sensitive creature and subject of general sympathy. I am particularly proud of this case, because it is a very difficult matter to straighten a sightless eye, for the eye makes

no effort to hold itself in the correct position as is the case when there is vision in both eyes.

The most frequent cause of blindness in old age is cataract. This is indeed very fortunate, for by a slight, but delicate operation a sightless eye is quickly transformed into a useful one, complete loss of vision changed to normal vision, and the sudden transition of the patient from darkness into light fills his soul with gladness which adds no little to the happiness of us, who have wrought the change. However we usually extract one cataract before the maturity of the other, and while there is still useful vision in one eye. Then of course the result is not so promptly appreciated by the patient, for he has not yet suffered the discomforts of blindness.

Extraction, or the operation for the removal of a cataractous lens, is the acme of ocular surgery on account of the delicacy of the tissues involved and the accuracy and exactness required in each step of the operation.

It could hardly be called a major operation for it is always done under local anesthesia, except where we have a very unruly patient to deal with, and the operation itself seldom lasts more than ten minutes; but, no matter how many times we have performed the operation or how expert we have become, the same degree of care must be excercised in the preparation and control of the patient, the preparation of the field of operation, the instruments, the eye solutions, the dressings and in each and every detail of the technique in order to obtain the best results.

Cataract extraction is called simple when no iridectomy is made and combined when there is. "Simple extraction" gives the ideal result, for the pupil is left round and normal and no trace of the operation is visible. Most oculists favor the combined method, claiming that there is less danger of prolapse of the iris or incarceration of it in the corneal wound. I am now using the simple extraction wherever possible, find the results equally good, and am able to get the patient out of the hospital sooner.

Nearly all the writers on ophthalmology tell us to keep the patient in the hospital for ten days or more after cataract extraction. I usually let them go home on the seventh day, and sometimes on the sixth. Of course the eye is still somewhat congested but it causes no trouble.

To demonstrate the appreciation and gratitude of these patients when their vision is restored, I cite this case: An old

negro man was led into my eye clinic at the Memphis Hospital Medical College recently, who had been totally blind in both eyes for several years from cataract. I sent him to the city hospital as a charity patient and did a simple extraction on both eyes, with a perfect result in each case. I gave him carfare to come to my office for the several necessary visits to have his eyes tested and glasses made.

He had no money to buy glasses so I bought them for him, and when I dismissed him he said: "Doctor, you been so good to me, aint' you gwine to give me a little pocket-money now?"

Besides its common use in cataract operations iridectomy is frequently used for two other purposes, namely the reduction of the increased intraocular tension in glaucoma and to make an artificial pupil—optical iridectomy. Glaucoma is the most dreadful of all eye diseases, and one of the most destructive to vision. A wide and deep iridectomy is made in this condition to open up the filtration angle at the periphery of the iris, and thus relieve the increased intraocular pressure which is responsible for the excruciating pain and loss of vision. Acute glaucoma is immediately, and usually permanently relieved by the operation but it is not so reliable in the chronic form of the disease. In this type we are often made to realize our short-comings and after doing everything we can to check its progress, can only look helplessly on while the vision fades to complete blindness.

Operations upon the sclera, with or without iridectomy, to establish a permanent filtering cicatrix, are now being made by many oculists with more or less success, but will never replace the iridectomy in acute glaucoma.

Three days ago, on December 16th., I was called in consultation by a local physician. I found a lady of sixty-two years in such dreadful agony that her groans and shrieks were audible before reaching the house. With little abatement she had suffered in this manner for two days, in consequence of which she was almost insane. It was a typical, violent case of acute glaucoma; she had had a similar attack in the same eye two months before and lost all vision except light perception. At that time an iridectomy would have saved her sight but now it was too late to do anything but relieve the pain. I sent her to the hospital and made a deep and broad iridectomy at once, under local anesthesia. Immediately the pain disappeared. She has suffered none since, and I have hopes of some improvement in her vision.

In opacities of the cornea causing blindness, we cannot do a great deal but can often accomplish something. Although the pupils of both eyes are completely covered by dense scar-tissue, yet if there is one small, clear spot in the cornea of either eye, a new pupil can be made in the iris just back of this clear point, and the patient will have vision enough to be of invaluable service to him. Much experimental work has been done in this field of surgery in an effort to replace these corneal opacities with grafts of clear corneal tissue taken from rabbits, guinea pigs, etc., but with little permanent success.

The sense of sight is the most precious of God's gifts to man; blindness the greatest curse that may befall him, death not excepted. The dividing line between these two conditions, light and happiness on the one side, darkness and misery on the other, is often very narrow. A little aid and the light shines on, a little neglect and the windows of the soul are closed forever while a human soul gropes on in darkness to the grave.

Notice.

Dr. W. W. Smithson, Secretary of the Mississippi State Board of Health, announces that the examination for applicants to practice medicine in Mississippi will be held at Jackson, Miss., on June 4th. and 5th. 1912, and that all applications for examination must be in the office of the Secretary at least ten days before the examination takes place. The fee for examination is ten dollars and twenty-five cents. Under the new law only applicants who are graduates of recognized colleges of medicine requiring a full four years' course will be allowed to stand the examination. Application blanks will be furnished by writing to Dr. W. W. Smithson, Secretary Mississippi State Board of Health, Jackson.

Personal.

Dr. C. R. Garraway of Brandon has moved to Laurel. The doctor has recently registered at the New Orleans Polyclinic for post-graduate courses.

MISSISSIPPI MEDICAL MONTHLY.

E. F. HOWARD B.S., M.D., Editor and Publisher.

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OFFICIAL ORGAN OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION AND ITS COMPONENT SOCIETIES.

SUBSCRIPTION ONE DOLLAR PER ANNUM.

On another page of this issue we produce the presidential address of Dr. A. G. Everett of Friar's Point, delivered before the Clarksdale and Six Counties Medical Society, which is an "eye-opener" with a vengeance. It paints a condition of affairs which, if Dr. Everett has not overdrawn the picture, and he should be in a position to judge correctly, should be remedied as speedily as possible.

We have occasionally heard some physician from the upper Delta, generally a young one, say something about discounts, but paid little attention thinking that it was some method employed at the option of the physician to secure ready cash, the planter or merchant occupying the position of the banker who discounts a note due in twelve months or more and charges a percentage for so doing. From Dr. Everett's address, however, it would appear that the Delta physicians are paying commissions of ten to twenty-five per cent. to those who procure them practice. This is not right from either an ethical or a business standpoint, and taken from either is surely a worse policy than making insurance examinations for a less fee than five dollars or doing straight contract surgery for mills or other corporations since, from the doctor's statement, it leads to underhand underbidding, so that the holder of the practice "suddenly realizes he has been supplanted by his colleague, and later learns that his worthy colleague is paying a larger bribe."

The writer knows quite a number of men in the Delta, has made several visits in that section and has met its men elsewhere, and has always been impressed by the fact that the Delta physician, on the average, is as well-equipped, as wide-awake

and as "clean strain" a man as one could wish to meet. It is a surprise to learn that they lend themselves to such things and we venture the prediction that as soon as President Everett's prod has thoroughly awakened them there will be "something doing."

Book Reviews.

THE HOME NURSES HANDBOOK OF PRACTICAL NURSING by Charlotte A. Aikens, formerly director of Sibley Memorial Hospital, Washington, D.C., etc. Illustrated. W. B. Saunders Co., Philadelphia. Price $1.50.

There is some very readable and instructive matter in this little book which would be of value to any beginner in nursing were it not that beginners frequently learn more from the illustrations than the text and many of these are of no value or misleading. Of what earthly use is a picture of the *micrococcus meningitidis cerebrospinalis* or of a bit of gut showing the necrosis of Peyer's patches to a nurse? These are merely useless, but one showing a nurse, who from her appearance ought to be playing dolls, "making an examination of the abdomen in typhoid fever" may lead some of Miss Aikens' readers to do valueless or even harmful manipulations, and the one showing the administration of a hypodermatic injection in the dorsum of the forearm will undoubtedly cause their patients much discomfort. Better stick to the text and continue to illustrate Meinecke's metal fountain syringe.

E. F. HOWARD.

TEXT BOOK OF OPHTHALMOLOGY in the Form of Clinical Lectures by Dr. Paul Roemer, Professor of Ophthalmology at Greifswald. Translated by Dr. Matthias Lanckton Foster, Member of the American Ophthalmological Society; etc. Vol I, cloth. $2.50. Rebman Co., 1123 Broadway, New York.

June 1912 Mississippi Med Monthly

In the present day rush of new books, which contain nothing new, and new editions, which are usually the same old ones with a new preface and a few added pages to help the illusion along, it is a great pleasure to read a new work which is both interesting and authoritative. Roemer presents his work in the form of clinical lectures, and, as the translator says in his preface, has done this so successfully that it frequently seems to the reader that the lectures must have been actually delivered and reported by a stenographer; the frequent repetitions and side remarks, so often used unconsciously by clinical teachers, occur so naturally that it is hard to believe they are all intentional. Volume I covers the methods of examining the anterior segment of the eye and diseases of the conjunctiva, cornea, iris and lens. As would be expected in clinical lectures, stress is given to a correct diagnosis and with that end in view much space is devoted to the symptoms found in the various diseases discussed. The treatment advised is that followed by the author in the clinic and elaborated as necessary to meet the emergencies that may arise as the disease progresses.

Of the substitutes for silver nitrate in the treatment of gonorrheal conjunctivitis the author says, "rarely have any of them proved its equal, none have ever proved superior," and he believes the future will bring better results from sero-therapy to be used with the local treatment.

In speaking of the relation of eczematous kerato-conjunctivitis and the scrofulous diathesis, Roemer expresses the belief that scrofulosis is a disease *sui generis,* which is complicated secondarily with tuberculosis in many cases, agreeing with Grawitz that it is a "disturbance of nutrition with special tendency to inflammation of the lymphatic system."

Pneumococcus ulceration of the cornea is fully discussed and in view of some of the present-day enthusiasts it is very refreshing to read of the serum therapy originated by the author, "it is announced, with a certain degree of satisfaction, that the serum treatment cannot supplant the old, radical operative treatment of ulcus serpens. I have never expected that it could. Such a demand is not reasonable; it is not even just. There is no therapy in ophthalmology which can completely supplant other therapeutic measures." By some, exception will be taken to the paragraph, "the totally unfounded fear of anaphylaxis."

A percentage of twenty-five seems rather low for the etiologic relation of syphilis to iritis, the prognosis of syphilitic iritis is given as very grave so far as complete recovery is concerned and relapses are declared frequent. Diseases of the lens, the last chapter, is quite up to the rest of this very instructive work. Should the forthcoming volumes hold up the high merit of the present one we will have an addition to our text books really worth while.

M. H. BELL.

INTERNATIONAL CLINICS. A Quarterly Of Illustrated Clinical Lectures And Especially Prepared Articles. Vol. I, Series 22. Edited by H. W. Cattell A.M., M.D., Philadelphia. J. B. Lippincott Co., Philadelphia. Price $2.00.

Those who do not have the services of a pharmacist at their disposal will appreciate "Some suggestions to the dispensing physician." There is also a highly interesting article on experimental poliomyelitis from the pen of Simon Flexner. The other essays are of the customary high order.

E. F. HOWARD.

SURGICAL OPERATIONS. A Handbook For Students And Practioners by Prof. Friedrich Pels-Leusden, Chief Surgeon to the University Surgical Clinic and Chief of the University Surgical Polyclinic in the Royal Charity Hospital of Berlin. Translated by F. E. Gardner M.D.,New York. Six hundred and sixty-eight illustration. Cloth $7.00 Rebman Company, 1123 Broadway, New York. Mississippi Med Monthly — June 1912

It will come as a shock to many Americans, who meet this work, and who have believed that we are the repository of all surgical knowledge to be compelled to change their views. As the author modestly says in his preface, he found it difficult to name his book. It is not an operative surgery, but it is more than a bald statement of surgical technique. Written in a pleasing style, that holds the attention without the fatigue which so many books on surgery cause, abundantly illustrated, every illustration in good taste, without any display of the "female form divine" which so many publishers are prone to, it is a work of which that hackneyed phrase might have been coined "No physician's library should be without it." The knowledge displayed is immense, and one can find the history or author of almost any operation given due credit. The translation, too, is excellent, giving us the spirit of the author's writing, which is too often emasculated in such works. We note but one error, (F. 642) where the term "indwelling catheters" is used. It will cause many some thought to recognize our old friend the self-retaining catheter in the "indwelling catheter"; while the translation is literal, it is too lit-

eral and should be corrected in a subsequent edition. The press work and binding is worthy of the subject, and is a pleasure to see this work in such fitting dress.

S. MYERS.

PELLAGRA. By George M. Niles M.D., Professor of Gastro-enterology and Therapeutics in the Atlanta School of Medicine, Atlanta, Georgia. Octavo of 253 Pages, Illustrated. Philadelphia and London: W. B. Saunders Company, 1912. Cloth, $3.00 net.

Pellagra having apparently come to make us a lengthy visit, and being from all reports by no means infrequent in the South, literature on the subject from a man of Dr. Niles' experience will be welcomed heartily. The author gives in concise, clear verbiage a description of the history, etiology, symptomatology and clinical course of the disease, a series of clinical reports, considers the pathology and morbid anatomy, diagnosis, prognosis and treatment and gives a very readable chapter on prophylaxis. The final chapter on animal experimentation and deductions therefrom gives much food for thought. Dr. Niles is a believer in Lombroso's theory of the etiology.

E. F. HOWARD.

AMERICAN MEDICAL DIRECTORY. Third Edition. Published by the American Medical Association, 535 Dearborn Ave., Chicago,

This new edition is of about the same class as its predecessors and is probably as litttle out of date as such a work can well be, for of course all directories are out of date before they get off the press. We note with some little amusement, however, that the Mississippi State Medical Assso-ciafion is credited with having twenty-six hundred and forty-eight members and the state with six thousand and thirty-two physicians. The population is given as one million seven hundred and ninety-seven thousand one hundred and fourteen. This gives one physician to every two hundred and ninety-seven of the population, a misstatement that even the most casual proofreader should have noticed. The secretary of the State Medical Association desires it understood that he did not give out these figures. What would happen if we were to demand representation in the House of Delegates of the A. M. A. on this basis?

E. F. HOWARD.

MISSISSIPPI MEDICAL MONTHLY

VOL. XVII. JULY 1912. NO. 3.

PRESIDENT'S ADDRESS.

D. J. WILLIAMS M.D.,

GULFPORT.

Ladies and Gentlemen and Fellows of the Mississippi State Medical Association:

This, our forty-fifth annual meeting, should, in some respects, be the most successful in the fifty-six years of our existence. In a review of our past, we find many things pleasant to reflect upon. Among them we note, with particular pride, a group of enthusiastic, self-sacrificing and scientific doctors, who formed the nucleus around which this great Association has grown. At its earliest organization, I find that the programme provided for addresses by members on the importance of local or county medical societies, and an address on the drainage of plantations to protect the health of those engaged in that which was then Mississippi's most important industry, planting.

At this meeting, too, I find the habit of "memorializing" the legislature originated.

It was at the meeting at Grenada in 1877, that the Association with its few faithful members drafted a bill for presentation to the legislature, providing for the creation and maintenance of a State Board of Health. They also had presented to the legislature for enactment a bill providing for the collection of vital statistics, and another regulating the practice of medicine.

These same measures we have advocated and succeeded in having enacted this year. A period of thirty-five years. Think of it! One half of the allotted time of man. My experience for the past ten years convinces me that they were not idle all this time, neither had they been bitten by the tse-tse fly. They were very much awake, improving at every opportunity, as best they could, the defective laws then in force.

The successful passage of the three measures advocated by this Association before the last legislature has not been due to our work alone. The honest efforts of the faithful representatives of this Association who have been before our legislative body time after time, should and do share in whatever honor is due from these measures having finally passed. To some of the old guard is due a larger share, if possible, of the honor. They have been undaunted by defeat; to Kendrick, Sutherland, Rowan and others, the satisfaction of seeing these measures become laws should be particularly gratifying. That they have been so long in being enacted by our law-makers is due in part to the medical profession.

The people had to be educated before there was a popular demand for such laws. Here was where our responsibility began. We ourselves not of one opinion, with discord among us, with different ideas and varying standards, were in no position to teach. Is it any wonder that it took thirty-five years? It should be different from this time on.

We have in the State Board of Health and its various departments, a body to establish standards and legalize them. It is for the State Board of Health now to say what a doctor in Mississippi shall be, and Mississippi shall have only the best. And here I want to say, that her present law will in no way lessen the opportunity of her poor boys. With one of the best public school systems of any state in the union, with ample provisions for her colleges and universities, with a medical department giving the first and second years equal to any, there should be no cry of "give the poor boy a chance." He has the opportunity, let him lay hold and embrace it. Laws will not make doctors, neither will laws make our health conditions better unless enforced by a healthy, moral sentiment of the people. It is your and my duty to create this healthy sentiment in favor of better living in our respective communities. How well we each have succeeded, the records of the past legislature show. How did your representative in that body stand on these questions effecting not you and me alone, but our homes, our towns and cities, our county and our state? Does the intelligent man who opposes these laws dare tell his constituents why? Has he the right to traffic in matters effecting your or my life? Does he dare plead economy facing disease and death? Dear Doctors, there was opposition; I refer you to the records. If your representative did oppose

these health measures, it is your duty, as guardians of public health, to make further efforts to bring him to a true knowledge of his responsibility and duty.

But let us analyze ourselves, find our faults. It is an unpleasant duty. My predecessors have probably wisely avoided it. I fear to put it off; I admit I undertake it with timidity.

We do not like to be told or reminded of our faults or defects, either physical, mental or moral, and are apt to resent such suggestions from our best friends. I am one of you and as a part of this Association I want our conditions improved. Considered physically, mentally and morally, we are second to none. Physically we have to have strength and endurance far above the average to do the arduous work required of us. No weakling need try. The mortality reports on the lives of doctors show the sacrifice of ten years of life. This means unusual hardship in view of his knowledge of how he should preserve his health and prolong his life. Mentally, the doctor with his accustomed active and varied thoughts, would eclipse all other professions were it not for his irregular habits. Morally, he emerges from the fiery trials of temptation and surpasses in purity all other classes of mankind. Where, then, his defects and from whence do they come? Shall I say, "his early training, his Alma Mater"? My experience as a member of our Board of Health convinces me that it is with our medical schools that many of our troubles with irregular doctors and the lack of enforcement of sanitary laws begin. I am glad to say I believe these conditions are fast passing.

But what are some of the evils we find existing? A larger percentage of the graduates, or those having completed four courses, fail to obtain license of our State Board of Health, than fail of those applying after the completion of the third course. The percentage of failures increases with the number of years spent in attendance at the medical schools after the third year; also with each year added after graduation. These facts were a source of worry to some members of the State Board of Health. It was no surprise to us that the percentage of failures did increase with each added year after graduation. The habit, known to many of us, of the majority of doctors not continuing their studies explains this. But that there was a larger percentage of failures of graduates or of full four-course men, fresh from school, was a surprise, was a fact, and called for a satisfactory explanation. We had made every effort to

have the examination a fair and impartial test of the applicant's fitness to practice medicine. A review of our work convinced us that this had been done. The examination questions on the various branches were prepared by the different members of the Board, and passed upon by the entire Board, the subject of each examiner being changed at each succeeding meeting. An examination of the grades of each applicant on the various branches, classified by number of years spent in study, revealed the trouble. The largest percentage of failures was on the primary branches.

These branches were, as a rule, dropped on the completion of the second year. The student completing the first and second year successfully was more unfortunate than the one who failed and consequently had to review and take these examinations again at the end of the third year. That which was at first apparently an injustice to the graduate and to the long term student, was in fact, only a fault of the medical colleges. The medical schools were preparing students to graduate and not to practice medicine. The students were often neglecting the primary for the advanced work, the advanced work being more attractive to both student and teacher.

The neglect or dropping of the primary studies, the very foundation of the student's future work and usefulness, caused his failure when put to a test. The giving of a final examination by our medical schools at the end of the second year on anatomy, physiology, chemistry, materia medica and therapeutics, is a mistake. We should have a thorough and complete knowledge of these branches all the time, and a final test at the time of our graduation. This would go far towards breaking up the habit of not pursuing our studies throughout our professional lives. It would give us our primary knowledge of drugs and their real uses at the hands of trained obeservers and teachers. Our instructions and knowledge of drugs and their action would not come to us as it does largely today through the enterprising pharmaceutical houses and their salesmen. They turn profit out of our ignorance at the expense of the confiding sick in our care.

Pursuing our investigation further, we found that these applicants had a smattering idea of phagocytosis, agglutinins, opsonins, bacterins, vaccines, side-chain theories and the like, but knew little or nothing of calomel, Epsom salts or quinine, drugs probably given one hundred times oftener than any other,

and ten thousand times oftener probably than they would ever make or use any of the examinations or tests referred to. They also lack a knowledge of contraindications of drugs. Why these defects in elementary medical education? Why this utter lack of fitness to practice medicine? Simply because the importance of the primary branches has not been sufficiently impressed upon the student and the time spent in study of these branches has been too short. Is there any wonder that we have among us so many therapeutic nihilists? Are you surprised that Christian scientists, osteopaths and chiropractics flourish and fatten, while we take the dry-rot and grow poorer? We have helped to create the demand for such service. I make no plea for an unquestioned faith in medicine, but we should investigate and learn the true value of drugs, for most of our work has to do with them.

In Nature's garden flourish plants whose roots, barks, flowers and fruit possess healing qualities we have failed to study. Knowledge of them will restore confidence essential to the successful practitioner.

We are but reaping the harvest sown. Study your cases, use your available laboratories and equipment to aid in making a correct diagnosis. Stop guessing; administer your remedial measures with clear-cut ideas of accomplishing specific results. Abolish "shot gun" prescriptions and the hasty prescribing of proprietary mixtures. Do not slight or dismiss hurriedly this work, and when your practice increases beyond that which you can do personally, employ a young, energetic, painstaking, competent assistant and pay him whatever his services are worth. Give more efficient service and help to raise the standard of the general practitioner, thereby increasing your field of usefulness and consequently the remuneration you receive, for, as in other professions, we get just that pay we deserve and nothing more.

Our medical schools neglect the proper instruction on medical jurisprudence and ethics, and this has had much to do with the unfavorable impressions made by doctors on our juries, the courts and the public.

The ridiculous, absurd, and many times extreme opinion given by self-constituted experts, has served justly to bring us into disrepute.

Our disregard of a code of ethics, has diminished the respect for us by the public. This disregard of ethics I have

found frequently to be due to ignorance of our duty to each other, and not to any intended wrong. The lack of observation of our obligations to each other, with its consequent differences among us, has been the indirect cause of the long delayed passage of the much desired Medical Practice Act. The people are demanding that we join hands and work together, guarding our own, and respecting the rights of each other. Our medical schools should grind some of it into us. I do not want to appear in the role of a fault-finder. Our medical colleges have and are doing more to raise their course of study than any other of the schools of science or of learning. One third of you probably had the privilege of applying for graduation after completing two short terms of five months each, and then you could enter late and a few could get an examination in advance of the regular examination, graduating with not more than eight months' school-work. But not so now. The influence of the committee on medical education of the American Medical Association, has spread through the various medical organizations, national, state and county; it has reached the people and today they demand better equipped doctors. In response to such a demand, we find medical schools uniting to increase their equipment and give stronger faculties. They are graduating men learned and skilled in their chosen work. Those out of school for some time, with defective training are handicapped, unless they have diligently improved every opportunity and continue in the training they must lose the race. No jockeying of the joking, jovial, good fellow of political type can put you under the wire. You are left. Let us hope that intelligence, education, training, ability and personal attention, rather than a pleasing personality, social standing, church or lodge relations will be determining factors in the selection of a physician.

Then what is the remedy? The industrious doctor of an investigating turn, finds it in a daily jog with his medical journals and text books. A vigorous work-out or rub-down in the presentation of cases and recitation of lessons at the weekly class-meetings, with an exchange of ideas and details of work done. A real test at your state and national association meetings in the presentation of papers based on experience and observation, with conclusions correctly drawn. In this way we can qualify. Get closer to your neighbor doctor; exchange ideas; learn what he knows and teach him that which he may

have overlooked. It will take the conceit out of both of you. Consult the masters through your journals and books. Develop your skill in diagnosis. Prescribe only after carefully taking into consideration the normal and diseased conditions; reason the effect of your therapeutic measures. Gather enthusiasm for your work at your county and state association meetings. It's a worthy feeling to feel unfit, if with it you determine to widen or broaden your knowledge in medicine. Such a determination comes to him who puts himself in contact with other physicians and feels the quickening influence of a good association. Most of us can learn something at the poorest and least instructive of our medical meetings. My heart goes out to the conceited bigot who quits his county medical society because he never learns anything at its meetings, or because they are not pursuing the course of study in which he is interested. I sympathize equally with those who employ him. His egotism effectually prevents his development; he keeps barely in the trail of the progress of medical science.

The greatest opportunities are coming to the general practitioner. The once familiar term, "family physician," has almost lost its meaning, being of late synonymous with obstetrician or baby-doctor. Ask an applicant for life insurance "Who is your family physician?" and note his puzzled expression.

The eagerness of the young, ambitious doctor to join the ranks of the specialists has lured many from general work, and today the general practitioner has very inviting field. With diligence and devotion to his work, by special study and preparation, the status of the family doctor will in a measure be restored.

The public today recognizes the usefulness and necessity of the specialist, but they do not realize the necessity of first consulting their family physician. Let us be competent to properly advise them when we are so consulted. When you fail to make an early diagnosis of T. B., you may have done your patient an irreparable wrong. If you fail to make an early or correct diagnosis of a case of dyphtheria, your error may not only cost the life of your young patient, but endanger the lives of others. If you fail to recognize the lesion or constitutional taint seen in the wayward, or too often in the innocent, your carelessness or ignorance bequeaths to the posterity of that patient, a weakling, an imbecile or a degenerate,

a burden to society and the state. Then how important that we be thoroughly prepared to do our work.

It is a lamentable fact that too often the regularly licensed physician fails to make a correct diagnosis and properly treat these cases, or to take the necessary precaution to protect others. Enough of this, else you judge me to be a pessimist.

The past year has been a particularly trying one on your officers. With our recent political changes, sentiment and legislation reversing itself with every new phase of the moon, it has been extremely hard to get our bearings.

Your committees have worked faithfully with the legislature; the results show for themselves. Our greatest difficulty has been to overcome the disposition for retrenchment. The providing for the health department of our state has been forced upon our legislature by the campaign of hygienic and sanitary education and the demonstration work that has been done throughout the state in the past two years.

The people have been awakened to a realization of the value of good health and the necessity of its protection and approve of a liberal appropriation for this department. They recognize the necessity of vital statistics and, in providing for these records, refuse longer to let our health department be crippled in the scientific prevention of disease.

By the acts of our recent legislature our State refused longer to contribute to the disgraceful attitude of our general government in its lack of protection of the health of its people, for, as a Government, we are fifty years behind Japan and are grouped with China and Turkey in the collection of vital statistics.

We are proud, not ashamed of our state; we are no longer humiliated by her refusal to guard her most sacred trust. We do confidently expect physical improvement and with sound bodies we can and do expect a healthy mental and moral growth.

Mississippi was the first state in the Union to conduct a regular educational campaign on hygiene and sanitation. Mississippi was the first southern state to provide for the collection of vital and mortuary statistics.

We are tired of being slandered without being able to refute malicious statements.

We have no great mineral deposits; no manufacturing centers. Our vast virgin forests of timber have been bought by

syndicates and are fast being cut away and marketed. But we have a soil unequaled in productiveness, in its response to careful cultivation, watered by abundant showers, springs, creeks and rivers. An ideal climate. The home of America's best citizenship. It is your and my duty as the licensed medical representatives of our state to let the truth be known, and where disease exists to lend our influence and energy towards stamping it out. The laws recently passed will make this easier. Our State Board of Health, a body composed of the choice of this Association together with the choice of the profession as made by our Governor, gives us in every way those among the best to head and lead in our state health affairs. This Board until the past two years was nothing more than an examining board, the entire time of the board given to public health affairs being not over eight hours each year and the greater part of these eight hours being spent in the appointment of our county health officers. Is it any wonder so little has been accomplished? Plenty to do, but nothing to do with, the so-called executive officer devoting such time as he could take from a general practice to answer correspondents and do that clerical work that was absolutely necessary.

Little disposition, less time, and no pay for the study of local conditions and predisposing causes of disease among one and three quarters million people.

Your Board of Health just retired has made a most excellent start; individually they exerted every effort to better our conditions, giving their time, talent and drawing from their own bank accounts such funds as they could spare to initiate a campaign of hygiene and sanitary education.

They were fortunate in securing the services of Dr. Fred J. Mayer, the pioneer of the hygienic and sanitary educational movement, who with his usual earnestness, brilliancy of thought and happy faculty of speech was the first to do the greatest work ever undertaken in the interest of our poor people. Here it is but right to tell you he came to us at a personal sacrifice, because he loved this work. In this, many of you did your part; when the available funds were short, you arranged for meetings, entertained the speaker in your homes, and when that was not always convenient, you helped to defray the expenses. The cotton mills and other corporative interests many times helped us. In behalf of the Board, I want to thank the railroads of Mississippi for their generous help in initiating this

work, for without their assistance, we would have failed. Some placed Dr. Mayer on the roll of employees as medical inspector, instructing all local agents to in every way aid in gathering together the people that they might learn how to protect their health. There was one exception, the L. & N., and it the greatest beneficiary of sanitary science. These facts should be on record and when the polluted political tide is running high and unjust legislation is about to be enacted, we who know these things should at least lend our protecting influence.

The present Board of Health has the most flattering and opportune time to accomplish much; the foundation has been laid and under the supervision of our Director of Public Health, Dr. Leathers, gifted in letters, with a scientific knowledge covering the entire field and an amount of energy rarely seen, our Public Health Department will be enabled to overcome almost any difficulty.

In the name of this Association, the doctors and the poor people of Mississippi, I wish to thank the Rockefeller commission for assistance in this work. Without their help the work would have fallen where Dr. Mayer left it. We would not have had a laboratory with its efficient director.

The thousands of sick and many times helpless patients would have gone untreated for that long over-looked, laziness-producing "hook-worm" disease. We thank God that He has placed riches in the hands of those having sympathy, a tender feeling and a disposition to help the poor and the sick.

Today we have small-pox scattered throughout our State, a reproach to scientific medicine, for which the carelessness and indifference of some of us are responsible. With united efforts in the discharge of our duty, as practitioners of medicine and as educators on hygiene and sanitation, there is no more excuse for small-pox, measles, typhoid, malaria or scarlet fever, meningitis or any other contagious or preventable disease existing within the borders of our State, than there would be for yellow fever.

Each of the diseases mentioned yearly exacts its heartless toll from the best and most exalted to the lowest and most humble families of our state, and when death visits a family under your or my care, you and I are responsible if that death is due to a preventable disease just in proportion to our efforts to prevent its further spread.

This is plain talk, but it is time for plain talk. We can

absolutely banish small-pox from our state in three months; typhoid in one year or less; malaria should go nearly as quickly as yellow fever, and with a National Public Health Department we could keep them out. It is to the discredit of the doctors in the hills that they have today as much or more malaria than they have in the bottoms or Delta.

What I have said is with the kindest of feeling. Some of you will agree with me; others will disagree. The conditions can only be entirely corrected when we as a unit realize our responsibility and teach our patrons the part they must do.

Health is our greatest natural resource, without which all other resources cannot be developed; its preservation confronts all communities, and the health of the people is entitled to the most careful consideration and study by the best brains of our country. The prevention of disease is our highest and best work.

Our health, happiness and prosperity are so interwoven that the regular practitioner of medicine, whose sacred duty is to prevent disease as well as treat the sick, is, of necessity, an important person in our social and commercial relations. Outside of the regular, can you show me any of the other schools of medicine, cures or healers, that have or are making any effort to protect or improve our health conditions. If not, are they doing their share in this great battle against disease, to prolong and make man's life free of pain and happier?

If the public could lay aside its commercial ideas and calmly view the noble men of our profession, doing their best to prevent contagion, banish disease and incidentally diminish the demand for our services, if they could only occupy the position of the true physician when he tries to relieve the distressed and suffering in a home where the grim visitor, death, is making his call, they would understand why we have worked so hard for better health laws.

We should demand and have a Public Health Department of the General Government, as outlined by the Owens bill; such a bill will not interfere with our constitutional rights. The general government has a right and should regulate conditions in one state when they are affecting the public health of another. The same old argument of constitutional rights was used by the patent medicine and impure food manufacturers against the pure food and drug act. Mention constitution or states' rights and the horde of politicians take to their holes

like prairie dogs. If they do conflict, give us protection against disease; give us health with its consequent flow of wealth and happiness, and change the constitution.

If this government can spend millions annually to equip and maintain the army, and more millions for the navy, all to protect us from friendly nations, why can't they spend something to protect us from tuberculosis which is annually taking a hundred and sixty thousand of our people, and making seven hundred thousand invalids? The annual loss in lives alone from this one disease is equal to the enlisted men in the army and navy. The yearly loss from typhoid fever alone, an easily preventable disease, is more than enough for the annual equipment and maintainance of our navy.

Think of it, twenty-eight thousand deaths annually; four hundred thousand sick and suffering. It is an expensive disease, costing the people of this government a hundred and fifty million dollars annually, and that is not all: not one civilized nation has a larger number of cases and consequently a larger death rate per thousand of population from typhoid fever than the United States. More yet: but one state in the Union contributes more to this disgraceful record of a filth-born disease than does Mississippi. It is a solemn, horrid tragedy, a needless sacrifice, a disgrace to any decent, intelligent community. Twenty-five per cent. of our population are today but little, if any, in advance of the savage Indians found here, in the disposal of their refuse.

The measures adopted to correct this enormous loss would largely contribute to the removal of diarrhoeal diseases with consequent decrease in infant mortality.

The doctors of this Association are doing their part in their respective cities, towns and communities. The ministry is lending its influence. The school-teachers are enlisted under our banner. The press is liberal, giving its space and editorials freely in this campaign. Why is it when our statesmen are told of these facts, they continue to turn a deaf ear and ignore our pleadings for help? Is it possible all evil is tracable to politics?

The recent work of the Marine Hospital and Public Health Department, under the wise supervision of Dr. Wyman, has demonstrated what can be and was done at San Francisco and New York in repelling and wiping out the bubonic plague and cholera. Do we hear any complaints from the other states

about their rights? No. But when a vacancy occurs in the head of a great service, notice how two sections, the South and West respectively clamor for promotion of the man who has served them best in protecting their respective borders. They overlook the vast interior with its railway systems. Great water courses with no governmental agency to supervise their sanitation; consequently as fast as we are rid of infectious diseases we become reinfected. It would be different if we had our fragmentary and scattered health agencies grouped together into one great department, headed by a Secretary of Public Health.

Have you done your part in an earnest effort to bring this about?

The complete vindication of Dr. Wiley is approved by the people. His resignation as Chief of the Chemical Department, with which he has so long been honorably connected, made necessary by the lack of support of the legal department, and of his superiors, is nothing less than a crime against public health. That commercial and political interests should boldly step in and control our Agricultural Department and deny the people of this country governmental protection from dishonest gain from the manufacture and sale of misbranded, rotten, adulterated and poisonous products is a shame, is robbery and murder. I trust Dr. Wiley's influence will be widened and the creation of a Public Health Department hastened.

Our system of education in our public schools needs revising. Our children at present are being schooled at the expense of their health. There is often a disregard of their physical welfare; hence the mental attainments sought are not realized, and if so, at too great a sacrifice of the physical. The age at which they are permitted to enter school is at least two years too early. Eye-strain, throat, lung and digestive troubles are common as results tracable to schools. The foundation of mental disease is laid early. The over-crowding, the undue pushing of young students, the cramming process with a lack of discretion on the part of some teachers, tells on the sensitive nervous organism. Who of you have not seen dozens of these students crying with fear of failure? Degenerative diseases are being fostered by the strenous school-life. There is a limit to mental as well as physical capacity. It is time to sound a warning to stop this reckless haste.

It is a well observed fact that when school closes for holi-

days, long or short, sickness falls off in greater or lesser proportions. It indicates the absolute necessity of a closer supervision by the health authorities.

Teachers and pupils unvaccinated or with T. B. or any contagious disease, should be excluded from school. A plan of every school-house, with its play-grounds, should be submitted to a committee of sanitarians for approval, and when the house shows improper lighting, heating or ventilation, or lack of fire escape, when the water supplies and drainage are defective or any condition affecting unfavorably the health of the pupils or teachers exists, the public school funds should be withheld from that school until such disgraceful, disease producing, death dealing conditions are corrected.

Our colleges should come in for the same supervisions. Especially does the system of the education of our young women need investigating. Too many date their lives as invalids from the time spent from home in school, or from the date of their marriage. Wise indeed is the parent who inves tigates carefully the school his daughter attends, and investigates the character of the man she marries.

We should have laws regulating the disgusting, filthy, disease-conveying, American habit of promiscuous expectoration.

Our prisons, jails and poor houses should be looked after in a way quite different from what they have been. The habit of the grand jury examining these places in a perfunctory way after semi-annual cleaning up, and reporting them in a sanitary condition, is a farce.

The release from our prisons by pardon or at the expiration of the term of sentence of those suffering with T. B., that they may go home or into other communities and spread infection, is a crime. These unfortunates should be cared for by the state until no longer a source of infection. We should have a home for epileptics; a school for the mentally defective.

The sanitary conditions of cities, towns, villages and communities should be investigated by a representative of the State Board of Health, and reports made and filed at once in the office of the Board of Health. All public buildings and places should be carefully inspected. We should have ample provisions for enforcing the pure food and sanitary laws. The work of all our health officers and their reports should be made public. There is nothing to be gained by secrecy. The people

of Mississippi have justly rebelled against it. If your neighbor has a contagious disease in his home, it is his duty to give notice and your privilege to know it.

We should help the health officer in the discharge of his duties, for they at best are unpleasant ones.

The health officer should give his entire time to the health department and should be well paid, as the storm of protests and indignities heaped upon him frequently, where he does his duties concientiously, renders it necessary that this work support him.

In small cities, towns and counties now having each its health officer underpaid, and giving but a part of his time and very poor services, a representative of the state health department could do the work, giving his entire time to studying and correcting the conditions of such an area or population as he could best serve; being free of local and political influence would vastly increase the effectiveness of his work, and this plan would be a matter of economy. With such a system properly executed, we would be able to prevent the further spread of disease.

Our sister state, Louisiana, is to be congratulated on the recent work of Dr. Dowling, and Mississippi should not be behind.

In conclusion I wish to thank the Council and the various committees for their untiring efforts in securing the measures they were appointed to look after. I wish to express my appreciation of the efforts of the chairmen of the various sections who have labored so hard to add to the success of this meeting, and deeply indebted am I to our most efficient secretary.

Mississippi State Board of Health.

List of successful applicants before the Mississippi State Board of Health for license to practice medicine in Mississippi. Eighty-seven applicants; forty-three passed.

June Examination, 1912.

1. William Henry Weaver.....Ocean Springs, Miss.
2. Challais Cross .....Strong, Miss.
3. R. Emmerson Smith .....University, Miss.
4. Hudgins S. Ellis .....Yazoo City, Miss
5. Thomas Von Horn .....Ethel, Miss.
6. Toxey Daniel Haas .....Mobile, Ala.

7. Robert Reece McNease ..... Bassfield, Miss.
8. Arthur Raymond Sanders ..... Sturgis, Miss.
9. Malcolm Benjamin Jernberg ..... Summer, Miss.
10. Roy Earl Mauldin ..... Waynesboro, Miss.
11. Murray Tate ..... Isoline, Tenn.
12. Azariah Paris Cobb ..... Lumberton, Miss.
13. Dudley Rook Moore ..... Holly Springs, Miss.
14. John Calhoun White, Jr. ..... Hazlehurst, Miss.
15. Ebb Brown Durette ..... Cordo, Ala.
16. Tully Joseph Liddell ..... Fayette, Miss.
17. Thomas Calvin Olliver ..... Weir, Miss.
18. William Cook Lester ..... Jackson, Miss.
19. William Alonzo Smith ..... Verna, Miss.
20. James Henry Newcomb ..... Pineville, Miss.
21. Victor Hugo Bean ..... Amory, Miss.
22. Arlander Houston Montgomery ..... Tishomingo, Miss.
23. Creed Scott Wilkins ..... Chiwalla, Tenn.
25. Wyat Ashbury Fleming ..... Theadville, Miss.
25. William Eureka Seale ..... Braxton, Miss.
26. Robert Matthews Leigh ..... Columbus, Miss.
27. James B. Gilbert ..... Meridian, Miss.
28. Dewitt Talmage Turnipseed ..... Sharpsburg, Miss.
29. Robert Marion Webb ..... Noxapater, Miss.
30. Eugene Reginald Shurley ..... Meridian, Miss.
31. Hosea Allen White ..... Baldwyn, Miss.
32. Joseph K. Crowder ..... Clarkson, Miss.
33. James Henry Williams ..... Ramer, Miss.
34. Howard G. Sevier ..... Tallulah, La.
35. Mervin Blanchard Moore ..... Liberty, Miss.
36. Carlos Daniel Kirby ..... Money, Miss.
37. Daniel Sartor Johnson, Jr. ..... Houston, Miss.
38. Robert Arthur Haggard ..... Mashulaville, Miss.
39. James Thomas Rainer ..... City Hospital, Memphis, Tenn.
40. Samuel Orr Price ..... Hernando, Miss.
41. Davis Herren ..... Tinsley, Miss.
42. Yancy E. Gordon ..... Chicora, Miss.
43. Frederic Homer Jones ..... Little Springs, Miss.

The Board of Health has recently published a bulletin on the "Typhoid Fly" which, the bulletin, not the fly, reached this office too late for notice in our last issue. It describes briefly the generation and habits of this omnipresent pest and the methods by which it may be exterminated. It is timely and well conceived and since it can be had for the asking there is no excuse for us not being widely circulated. For copies address State Board of Health, Jackson, Miss.

Notice.

Dr. I. W. Cooper of Newton has been appointed chairman of the section on pediatrics, vice Dr. L. D. Dickerson of McComb resigned.

MISSISSIPPI MEDICAL MONTHLY.

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S. MYERS M.D., Business Manager.

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OFFICIAL ORGAN OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION AND ITS COMPONENT SOCIETIES.

SUBSCRIPTION ONE DOLLAR PER ANNUM.

"Word is received that at the comemncement exercises of the Mississippi Medical College, Meridian, May 11, it was announced that the college would not be reopened on account of adverse legislation passed by the last legislature." *Journal A. M. A.*

Lest it be inferred that this "adverse legislation" was failure of appropriation or some law aimed at the school, it should be stated that the only law passed by the recent legislature at all affecting the Meridian Medical College is the Medical Practice Act. Now that we have a law regulating the practice of medicine that will hold water and keep out incompetents, we see the truth of Dr. Buchanan's statement, he being a member of the Meridian College faculty at the time, at the Oxford meeting of the State Association: "There is no college in Mississippi fit to graduate physicians." We congratulate the Meridian faculty on having seen that it is better to have no college than a poor one.

The Department of Health of the City of New York has recently given birth to one of the msot joyous utterances ever perpetrated. In connection with an effort for the control of venereal diseases, a most laudable purpose, the Department has issued a set of resolutions in which, after a preamble to the effect that venereal diseases are infectious, communicable and preventable and a menace to public health and that no administrative control of such diseases is possible without a system of notification and registration, they provide that all public institutions in the city must report "the name, sex, age, nationality, race, marital state and address of every patient under observation suffering from syphilis, in every stage, chancroid, or gonorrhœal infection of every kind—"and

"*Second*, That all physicians be requested to furnish similar information concerning private patients under their care, excepting that the name and address of the patient need not be reported."

There are five more sections but we stopped here, being able to see a joke when it hits us in the face, and haven't been able to get any further. We suggest as a form for the reports:

New York, (*any old date will do.*)

I hereby certify that I have today diagnosed a patient as having syphilis, chancroid or gonorrhœa (*don't make any difference which.*)

Signed ———————— M.D.

A few thousand such certificates will undoubtedly be of immense value in stamping out venereal disease in New York and the plan should be adopted throughout the world. The poor man goes to the hospital and is reported, or remains untreated. The rich man goes to his doctor and is not reported. Any man who does not want to be reported and who falls into the clutches of an unscrupulous physician, and while of course we are all ethical and honest there are some who come under this head, will have to pay a whopping big bill to keep his name off the records.

Society Proceedings.

East Mississippi Four County Medical Society met at Houston May 21st., great interest being manifested though the attendance was below the average. Dr. C. D. Davis of Houston read a paper on periostitis so warmly received that the essayist was requested to re-read it at the August meeting to be held at Tupelo. We always have our best meetings at Amory and Tupelo because of their accessibility and the influence of the wide-awake, progressive, professional spirit of the local men. After the discussion following Dr. Davis' paper, an experience meeting was held with Drs. John Walker, Hansell and E. P. Wilson leading off.

F. J. Underwood.

Covington County Medical Society met at Mt. Olive June 11th., the following being in attendance: R. R. Welch, Kola; Jas. Welch, Collins; J. H. Temple, Seminary; Jno. McIntosh, Mt. Olive; M. L. Flynt, Mt. Olive; A. S. Calhoun, Mt. Olive; Jno. Gibson, Collins; G. W. Wallace, Arbo; W. W. Davis, Ora; W. N. Blount, Collins; H. F. Garrison, Seminary. Dr. Wallace read a paper on Medical Ethics that was heartily received and fully discussed. The society decided to hold bi-

monthly instead of quarterly meetings in future, and will therefore hold its next August 13th. at Mt. Olive.

H. F. Garrison.

Tate County Medical Society met in Thyata Wednesday, June 5th. Present were Drs. Hosey Wilson and Eason of Coldwater; Ellis, LaVerne, Bucey and Smith of Senatobia; Gilbert and Bowen of Tyro; Eason and Barnett of Chulahoma; Thomson and Powell of Independence; McCauley of Marianna; Murphey of Arkabutla; Kisner of Looxahoma and Collins of Thyatira. Dr. Collins presented a case of Hydrencephalocele. Dr. Thompson read "Report Of A Case Of Diabetes In A Child Eight Years Old." Dr. Wilson read "An Appeal for More Surgery and Better Surgery In The Country." Dr. LaVerne read Salvarsan—Its Administration." These papers were read and well received, being freely discussed by all present. After the society adjourned the doctors were entertained in the homes of Mr. Dandridge and Dr. Collins where a most delightful repast was served. The attendance at this meeting shows that the physicians of this country are fast waking up to the importance of the county society and are trying to get the most good out of it being present at every meeting possible. Many things of importance to the physicians themselves were also discussed.

W. D. Smith.

Letters to The Editor.

Editor Monthly:

We note your strictures in the June Monthly anent President Everett's rebate article, also in the June Monthly. We are somewhat surprised to find you falling so readily into the error of assuming that Dr. Everett's personal experiences are typical of the Delta profession.

There is, and has been for years, a custom, practically universal so far as pertains to our little universe up here, of the planter assuming all liability for his tenants' medical bills. These bills are often paid monthly, sometimes annually, and the planter contends that he is due something for guaranteeing and collecting these accounts. The physician would lose vastly more than ten per cent. if he did work for these itinerant tenants on their own liability. He would have to pay a collector ten per cent. and then have only about fifty per cent. of his accounts collected. As it is he gets the full amount, less

the ten per cent. for insurance and collection, whether the tenant lives, dies or moves.

This is no sense a bid for practice. No planter ever sends for a certain physician simply because of this ten per cent. for every other physician likewise gives the ten per cent.

This discount of ten per cent. works no hurt to the tenant, as he is charged the same fee by the doctor whether he pays cash for the service or whether it is charged to the landlord, except in surgical cases when the landlord is charged more according to his ability to pay.

As to the twenty and twenty-five per cent. rebates, we have had little personal observation. They represent isolated cases and can no more be stopped than can we stop certain physicians from putting a minimum value upon their services and charging accordingly.

Yours truly,

JAMES W. GRAY.
T. M. DYE.

Clarksdale, Miss., June 8, 1912.

Comment: The above certainly changes the appearances of things and puts the Delta, in our estimation, back in the paradise where it properly belongs. We are glad to have the correction, but suggest that as the address of Dr. Everett, having been read in open meeting, was sent us for publication, without comment, by no less person than Dr. Dye himself, we still feel we were justified in concluding that it was an official utterance of the Clarksdale and Six Counties Society and also that further "cussing" should be addressed to Dr. Dye.

EDITOR.

New York, June 18, 1912.

Editor of the Mississippi Medical Monthly,
607-8 First National Bank Building,
Vicksburg, Miss.

In your June number of this year on page 43 you publish a review of "Surgical Operations" by Prof. Pels-Leusden, translated by Faxton E. Gardner M.D., of New York. In this review, the following sentence occurs:

> "We note but one error in (F. 642) the term "indwelling catheters" is used. It will cause many some thought to recognize our old friend the self-retaining catheter in the indwelling catheter."

I spoke to Dr. Gardner about this and he sent me a letter under date of June 10th. 1912, which we are enclosing herewith. Will you refer this letter to Dr. Myers and oblige,

Very truly yours,

REBMAN COMPANY,
W. P. Rebman, President.

F.-J.R's, Enclosure—1.

6-18-12.

Dear Mr. Rebman—

Referring to Dr. Myers' comment on the words "indwelling catheter" used by me in Pels-Leusden's text-book's translation, I beg to say that: indwelling catheter, retained catheter, permananent catheter and inlying catheter are in New York, Boston and Philadelphia, at least, four synonymic terms used designate a catheter introduced in the urethra and fastened in situ and that indwelling catheter far from being a neologism coined by me is current in genito-urinary text-books (see Keyes.) The term self-retaining catheter is quite another thing; it applies to catheters of for instance the Malecot or the dePezzer type (represented in fig. 599 and 600, page 643) which after being introduced remain in position by themselves without any fastening, owing to their special disposition.

Very truly yours,

FAXTON E. GARDNER,

Lecturer on Genito-Urinary Surgery in the N. Y. Polyclinic Medical School and Hospital.

Personal.

Dr. W. B. Harrison of Whitney, Sunflower County, has moved to Mattson, Coahoma County.

Dr. E. J. Johnson of Yazoo City will move to Memphis July 1st. where he will enter partnership with Dr. J. A. Crisler.

Book Reviews.

DIFFERENTIAL DIAGNOSIS. Presented through an Analysis of 385 cases. By Richard C. Cabot M.D., Assistant Professor of Clinical Medicine, Harvard Medical School. Second Edition. Octavo of 764 pages illustrated. Philadelphia and London: W. B. Saunders Company, 1912. Cloth, $5.50 net.

If one were asked to mention the most thoughtful, the most helpful book offered to the medical profession in a decade, no mistake would be made in naming Cabot's Differential Diagnosis. A careful reading will give all the advantages of a post graduate course, and no one can finish it without being a better diagnostician; for in the groups of cases discussed nothing obvious is presented, but the difficulties of diagnosis are carefully brought out and the diagnosis in all cases seems reasonable.

The various groups with illustrated cases are Pain, Headache, Lumbar Pains, General Abdominal Pain, Epigastric Pain, Right and Left Hypochondriac Pain, Right and Left Iliac Pain, Axillary Pain, Pain in

Arms, Legs and Feet, Fevers, Chills, Coma, Convulsions, Weakness, Cough, Vomiting, Hematuria, Dyspnœa, Jaundice, Nervousness, with a case illustrating each type of a prominent symptom under each type. When confronted with a puzzling case it is a pleasure to read and be helped to diagnosis by this work. We cordially recommend this book to every practitioner, and know it will be like his thermometer—always at his right hand.

A second volume, covering the subjects necessarily omitted is promised, and will be looked forward to with impatience. The W. B. Saunders Co. have given it a typographical dress worthy of it.

S. MYERS.

DISEASES OF THE GENITO-URINARY ORGANS AND THE KIDNEY. By Robert H. Greene M.D., Professor of Genito-Urinary Surgery at the Fordham University, New York; and Harlow Brooks M.D., Assistant Professor Clinical Medicine, University and Bellevue Medical College. Third Revised Edition. Octavo of 639 pages, 339 illustrations. Philadelphia and London. W. B. Saunders Company. 1912. Cloth, $5.00 net; Half Morocco, $6.50 net.

We often have occasion to lament the fact that the writers of works on medicine, while thoroughly posted on their subjects, have such a poor command of English that they are unable to express clearly the ideas they seek to impress. In this work, written by two men, this fault is glaring, and diminishes the value of an excellent work, one that has passed through three editions. For example, they say "The Erlanger instrument affords the greatest range of possibility" when they mean "the greatest range of usefulness." All through the work are scattered "bugs" in English. For instance, chapter IX is entitled Bright's Disease, and they give the pathology of Bright's Disease, etc., when every book of late years is content with the term nephritis. One can get their therapeutic status on reading "that drachms 2 of voilet flowers steeped for five minutes in one pint of boiling water in acute nephritis stimulates diaphoresis and is also a soporific." That's something H. C. Wood and Torald Sellman don't know. Their reasons for excluding salt in kidney diseases are amusing, to say the least. In epididymitis, they seem never to have heard of strapping the testicles, a procedure that gives instant relief; nor of puncture of the tunica albuginea, a procedure introduced by Vidal de Cassis, and one that makes a suffering patient ever grateful, so immediate is the relief.

We will further say that the illustrations, in sympathy with the text, have an apologetic air, and look like they were drawn by the office boy. Better ones can be borrowed from any instrument dealer.

This a good work, and if dignity allowed a writer of good English to be called in and clarify it, it would be one of the best on the market.

S. MYERS.

PRACTICAL MEDICINE SERIES 1912. VOL. I. General Medicine edited by Drs. Billings and Salisbury. Vol. II. General Surgery edited by Dr. Murphy. The Year Book Publishers, 180 N.Dearborn St., Chicago. Price per volume $1.25, series, $10.00

These initial volumes of the 1912 series well uphold the standard set by previous series of this the most convenient of the year books that the reviewer has seen. They are even more elaborate than heretofore and many of the illustrations are excellent.

E. F. HOWARD.

MISSISSIPPI MEDICAL MONTHLY

VOL. XVII. AUGUST 1912. NO. 4.

*INFANT FEEDING.

MARGARET CARAWAY M.D.,

GULFPORT.

Holt says: "The question whether a child shall be strong and robust or a weakling, is often decided by its food during the first three months." Whether or not this is true, there is certainly no more important branch of pediatrics than that of nutrition.

We are all agreed that the ideal food for infants is healthy mother's milk, but for various reasons this is not always available and it is a deplorable fact that the present tendency is toward artificial feeding.

Not many years ago a "bottle baby" was something of a novelty, but now it is not unusual for bottle cover and bottle to be provided along with the clothes and other necessities of the coming baby.

This attitude against maternal nursing on the part of young mothers is often due to lack of information, and might be easily altered if the physician impressed upon them the great benefit to the baby of mother's milk, and the actual protection it affords against disease, for now our best authorities are agreed that aside from its nutritional value, the mother's milk affords in some measure to the nursing infant an immunity against most contagious diseases.

Of course there are conditions in which maternal nursing is absolutely contra-indicated, as where the mother is suffering from tuberculosis, either active or latent, or from any serious chronic disease; but every effort should be made to induce a mother of average health to nurse her baby.

Sometimes it happens that an apparently healthy and well-developed woman is unable to nurse her baby because of a deficient supply of milk. I think the tendency in these cases is to give up too soon, for often with a little perseverance the supply of milk will increase surprisingly and particularly is the secretion of milk stimulated in these cases by the persistent nursing of a hungry baby at regular intervals.

*Read before the Harrison County Medical Society.

In other cases a somewhat delicate mother may really have an inadequate supply of milk, and then the rational thing to do is not to take the baby from the breast but to resort to supplemental feeding. I think this class of cases is often mismanaged by either giving up nursing entirely or keeping the baby on starvation rations at the breast and dosing him for every ailment imaginable from colic to "Bold Hives" when what the little chap really needs is a square meal. Usually it is not difficult to diagnose this condition, as the mother's breast at the time of feeding is a pretty accurate gauge in these cases if the mother is encouraged to continue nursing; but when at feeding time her breasts are flabby and empty, simply prepare a complete meal for the baby and postpone his breast feeding entirely; she will usually find at the next feeding period that she has a sufficient supply, and very often by the addition of one or two bottles during the day she can nurse satisfactorily during the usual period of lactation.

Now a word as to what this supplemental feeding shall be. As a rule I do not favor condensed milk, but in cases of this class I have found a good brand of such milk serve a splendid purpose when properly diluted and fresh cream or olive oil added. I believe the reason for this is that usually the milk of these mothers is not up to the standard in fats, and by using the condensed milk with cream or oil added you supply in direct measure that deficiency, and also the excessive carbohydrate of condensed milk in soluble form provides an easily digested food element that aids nutrition in much the same way as the fats.

Another less usual condition encountered in maternal nursing is where you have an abundance of milk but of such poor quality that it falls short of proper nourishment for the child. This condition is usually caused by an excessive ingestion of fluids with the idea of increasing the milk, and as a rule after the excess of fluids is omitted, the secretion, or rather the transudate, becomes greatly lessened and often it is necessary to resort to supplemental feeding.

In those cases where artificial feeding must be depended on entirely, the wise course is to follow nature as nearly as possible, and to do this we must have a clear idea of the composition of woman's milk and then plan our substitute accordingly.

Woman's milk is composed of the same five elements that go to make up a perfect food at any stage of life: proteids, carbohydrates and fats with water and inorganic salts, and these are so proportioned and combined as to conform to the infant's feeble powers of digestion.

The most available natural food that approaches mother's

milk in composition is fresh cow's milk, and experience has proved that it may by modification be made an acceptible substitute for mother's milk. By the modification of cow's milk is meant its adaptation to the purpose of infant feeding. Primarily the milk should be fresh, not over twenty-four hours old, should contain no preservatives, should be clean and from healthy animals. Herd milk is preferable to that of a single animal and it should contain no pathogenic organisms.

In comparing cow's milk to mother's we find an excess of proteids and salts, and a deficiency of sugar while the percentage of fat is about correct; the reaction of cow's milk is acid, woman's is alkaline.

The modification in favor now is the percentage method, also called the American method, which aims at something definite, exact and at the same time flexible. By its use we are able to adapt the food elements to the particular child, for it has been long proved that a mere mixture of proteids, carbohydrates, fats, etc., in the same proportion as in woman's milk, will not give the same results for the reason that these different food elements are not all of the same composition; particularly the proteids of woman's milk differs widely from that of cow's milk, hence in modified milk we find the greatest difficulty arising from the infant's inability to digest the proteids, and to obviate this difficulty we begin with a much lower percentage of proteids and gradually increase them as the infant is able to digest them; or in some cases it may be necessary to peptonize or partially peptonize the milk temporarily. There is usually but little difficulty in a proper adaptation of the fat and sugar as we have only to deal with quantity and not difference of quality. On the whole, the only really acceptable substitute for mother's milk is properly modified cow's milk.

Regularity as to time and amount of feeding is if possible more important in the artificially fed than in the breast-fed. A general rule is to feed every two hours during the day up to the third month, gradually increasing the time to three hours till near one year old, when every four hours will be sufficient; while beginning with one to one and one-half ounce at a feeding, gradually increase until by one year the infant may take from seven to nine ounces.

As to the various infant foods on the market, none of them are to be considered a substitute for breast milk, and are unsuited for permanent use; they almost uniformly have a great excess of carbohydrates and a deficiency of fat, while the proteids are frequently vegetable. Their continued and exclusive use is very likely to lead to grave disturbances of nutrition, such as scurvy, rachitis, etc. I have only dealt so far with normal conditions in infant feeding and have not

even touched on these serious conditions in which all methods and foods seem to fail, for while in a sense the same principles should apply, yet in pathological conditions in the infant as well as in the adult, all ordinary rules may need to be suspended or altered to conform to existing conditions. However in the average infant with the ordinary digestive disturbances, it is well to try to locate the source of trouble, whether gastric or intestinal; if gastric you will usually encounter the coated tongue, vomiting or belching of gas, regurgitation of food and water; while if the trouble is intestinal, the result will be colic, flatulence, distention of abdomen, diarrhœa or constipation, with curd in the stools. Often to correct these conditions a change in the percentage of the food elements is all that is necessary. For the vomiting or regurgitation of sour masses, a decrease in the fats and probably the sugar is indicated; for habitual colic, lower the proteids; for constipation an increase of fats and sometimes proteids; if vomiting is immediately after feeding, lessen the quantity.

The golden rule in infant feeding as elsewhere, is prophylaxis. Don't wait till the infant is ill to be careful of his food.

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*MEDICAL ETHICS.

G. W. WALLACE M.D.,

ARBJ.

The scope of medical ethics cannot be compassed in a paper of this length, so I shall content myself with first giving verbatim the code of ethics adopted in Dec. 1902 by the Birmingham (Eng.) and District General Medical Practitioners' Union.

SECTION 1.—General.

I. No member shall lower the dignity of the profression by the following or any similar practices:

(a) Soliciting private practice either personally or by advertisements in newspapers, by placards, or by the distribution of circulars, cards or handbills.

(b) Deriving pecuniary benefits from the sale of any secret remedy.

(c) Entering into any compact with a chemist to receive a share in the profits arising from the sale of medcines prescribed or medical or surgical appliances.

(d) Publishing or sanctioning the report of cases or operations or letters of thanks in non-professional journals or newspapers.

*Read before the Covington County Medical Society.

(e) Covering persons who are not registered under the Medical Acts.

(f) Keeping an open shop.

(g) Agreeing to attend any patient on the terms of "no cure, no pay."

SECTION 2.—Consultations.

1. No member shall meet in consultation any practitioner who is not registered.

2. Every member shall endeavor to observe punctuality in consultation appointments. If the medical attendant has not arrived within a reasonable time (e. g. a quarter of an hour) after the appointed hour, the consultant shall be at liberty to see the patient alone and should leave his conclusion in writing in a closed envelope.

3. The duty of announcing to the patient's friends the result of the consultation shall be mutually arranged between the medical attendant and the consultant.

4. Differences of opinion should not be divulged unnecessarily, but where there is an irreconciliable difference of opinion, the circumstances should be frankly and impartially explained to the patient's friends. It is open to them to seek further advice, either, as is preferable, in consultation with those already in attendance or with the medical attendant only.

5. The attendance of a consulting practitioner shall cease when the consultation is concluded unless another appointment is arranged by the medical attendeant.

6. When it becomes the duty of the practitioner occupying an official position to see and report upon a case of illness or injury, he should, as a matter of courtesy, whenever practicable, communicate with the practitioner in attendance so as to give him the opportunity of being present. The practitioner seeing the case officially shall scrupiously avoid interference with or remarks upon the treatment or diagnosis that has been adopted.

7. When a consultant in his rooms sees a patient at the request of his medical attendant, it is his duty to write a letter stating his opinion of the case with the mode of treatment he thinks should be adopted.

SECTION 3.—Attendance on Behalf of Another Practitioner.

1. A member entrusted with the practice of a professional friend, during sickness or absence, shall not charge either the patient or the absent practitioner for his services, except in the case of a special arrangement between the practitioners.

2. A member called upon in an emergency to visit a patient, who under ordinary circumstances, would have been attended by another practitioner, shall, when the emergency is provided for, retire in favor of the ordinary medical attendant.

3. When a member is called to a case of obstetric emergency during

the temporary absence, from any cause, of the proper medical attendant, he shall cease his attendance when the emergency has been provided for, or on the arrival of the proper medical attendant, but if in the meantime he has assisted at the delivery, or has been detained for a considerable time, he shall be entitled to receive a portion of the fee. Nevertheless the emergency practitioner shall be entitled to attend in a subsequent confinement if asked to do so, but if he has attended at the request of a practitioner, he shall obtain the consent of the original attendant before doing so.

4. When a member is consulted by a patient whom he has previously attended during the course of the same illness at the request of another practitioner, he may propose a consultation with the said practitioner, but shall decline to take charge of the case.

SECTION 4.—Interference.

1. When a member is requested to attend a patient already under the care of another practitioner (the case not being one of emergency), he shall decline to do so, except in consultation with the practitioner in attendance, or, in case the consultation be not agreed to, until the practitioner in attendance has been informed (in writing, if possible) that his services are no longer desired.

2. When a practitioner is consulted at his own residence, it is not necessary for him to inquire if the patient is under the care of another practitioner, but if the fact shall transpire, the interest of the patient or courtesy may require that he medical attendant be informed of the consultation and its results.

SECTION 5.—Miscellaneous.

1. No member shall receive commissions from tradespeople in return for recommending them or their wares, or from dentists for recommending patients, nor shall he pay commissions to hotel proprietors, lodging-house keepers, monthly nurses, midwives, or others for the introduction of cases.

2. No member shall wittingly allow himself to be described as "following" a midwife.

3. No member shall associate himself with medical aid associations or clubs in which a house-to-house collector is employed, unless the club declines to accept new members.

4. Members shall not permit their names to appear on any premises of which they hold no tenancy, except in widespread country districts. This does not apply to legitimate branch surgeries.

5. A scale of fees shall not be publicly exhibited.

Our own conditions may modify, to some extent, some of the foregoing, but on the whole the requirements are good.

The subject of medical ethics is one that is constantly before the profession and one that is attracting quite a deal of attention in many countries at this time.

Under the semi-official recognition of the Faculty of Medicine in Paris, a course of lectures on the subject has been delivered. In Germany, we hear of the establishment of Medical Courts of Honor before which medical men may be tried for breaches of professional rules and these courts have the power of inflicting fines and other punishments.

Only a few days ago, however, one of these Courts of Honor, backed by the Emperor of Germany, relieved an army surgeon of his position for refusing to fight a duel with another surgeon who had challenged him. Thus the Emperor backs up the semi-barbarian practice of duelling and lends not an ear to the man, who, though bemeaned, had refused to degrade himself and his profession.

However, this will bring good results in the end, for the German press is alive to the situation and the legislators have expressed themselves in no uncertain tone.

In Great Britain and in the United States, there are no schools of medical ethics as such where the subject is taught nor is any considerable stress laid on it in any medical school with which I am familiar.

A basis for medical ethics is no easier to find than a basis for general ethics, which latter, early philosophers, as Socrates and Plato, were content to let common opinion and current morality set the standard. Nor has this view been materially altered to this day, for the better kind of current opinion, or representative medical opinion, is generally accepted.

The tripod of medical ethics supports these principles: 1. The medical practitioner should obey the golden rule in relation to his colleagues. 2. That the medical man should regard the duties in connection with his profession as the highest among those which he is called on to perform. 3. That in dealing with patients, the interest and advantage of their health should alone influence his conduct toward them.

Commenting on these, I would say that it is easy to give kindness for kindness, nor should one reciprocate, in like sort, with those who have treated him unfairly.

My relations with Covington County physicians have been of the most pleasant and helpful kind and if they have enjoyed the work as much as I, there are no regrets.

It is merely stressing to say that no physician should so act toward his fellow practitioner that his sincerity would be questioned. Straight-forward honesty will usually win and best of good feelings can be maintained.

A man called both another doctor and me. Both coming, he did not know how to get out of a supposed dilemma. This was plainly evident to the doctors who told him he could have either continue the case and suggested he choose the one living

the nearer. Evident relief manifested itself as the man's countenance lit up. 'Twas just a little lesson in mutual confidence.

This leads on to the duty of medical men to cherish a pride in their profession and disparage it not by act or word, but endeavor to increase the public esteem in which it is held by beneficient and worthy acts.

A lack of adherence to this principle; laxity or extravagance in demeanor or dress; under-rating the importance of medical ethics, privately or publicly, unkind comments made of colleague or patient—these and more not only tend to destroy deserving public confidence, but are manifestations of the untutored minority that affect unjustly the ethical majority.

Casting about you will find that the man who does not give his support to the local and state medical societies, does untold damage. First. His patients, if they think at all, think that the society cannot be much or their doctor would join it. This doctor may get some consolation by believing his patients think him above the society, but later he finds, as his patients come to think intelligently, that he no longer stands out in the headlines of the front page, but is relegated to the small type among the supernumeraries. Second. Untold injury is done the offender by his own acts. Third. The blind and even some who see are wont to believe that medical organization means the development of means and devices for enriching the profession at the expense of the laity. 'Tis as hard to make them believe it is for the direct scientific advancement of the physician and indirect increased service to them (at the same cost to them), as it is to penetrate many an ankylosed brain with the fact that ground itch and hook worm diseases are practically synonymous terms, aye, even more, to induce some that there ever was a hookworm only in the minds of a few who live off somewhere and are a self-constituted body who use this means of extracting money from the public.

Yet, as a whole, the trust placed by the public in the medical profession is not exceeded by any other profession, so it behooves the physician to be true to its interests.

Every patient is entitled to as good service as can be had in the community in which he lives and it is the duty of the profession to maintain a standard above reproach.

It means a certain amount of work to keep abreast of the times, but one's duty should spur him on even if his pride and interest in his work were not the chief factors.

I have said that the interest and advantage of the patient's health should alone influence the physician's conduct toward them. One should curb all other desires, be they social, phy-

sical, or financial. To discuss all these might carry us aside somewhat, so they are only mentioned that your imagination may enlarge upon them.

Soon we are to face another and a new proposition (for Mississippi doctors.) The last legislature made new requirements, chief of which from the standpoint of this paper, is the act requiring the reporting of births and deaths and the information going with these.

I trust that none of our medical men will be lax in these matters for again our three basic principles are involved.

Occasionally one will find people do not want a death reported and the proper diagnosis given or do not want their homes quarantined on account of a contagious disease. I have known of a physician in New Orleans who lost the practice of a family because he reported a case of measles in their home. Too, I have heard of a physician who helped to keep secret the fact that a family had a contagious disease in the home. Now if a physician helps in eluding the constituted authorities and wilfully breaks a law, what can you expect of the laity? What do you suppose the laity thinks of such a physician regardless of the aid given?

True the doctor is expected to be more benevolent than those of other profesions and this benevolence is to be extended regardless of race, creed, or social position, but it surely is not proper nor is the profession called upon to shield the public or any part of it when right and justice demand a different course.

I would add in closing that this subject should be discussed often in medical societies. If members fear some one's feelings are going to be ruffled, it is a good indication that all is not as well as it should be and the sooner it is righted the better.

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*REPORT OF CASES.

H. C. BUCK, M.D.,
FRIARS POINT.

I feel an inclination to report these cases for two reasons, one is they are rather rare, at least some of them are, the other, the fact that they occurred in a negro family composed of three persons, a man, his wife and a daughter about twenty-five years of age.

On March 7th. 1909 I was called to see the man's wife, found her with pneumonia, she had an uneventful recovery, on

*Read before the Clarksdale and Six Counties Medical Society

March 14th. 1910 was called to see the girl, found her with a severe case of dropsy, the extremities and abdomen badly swollen, on May 10th. the swelling was so severe I resorted to "tapping" removing a little over two gallons of fluid, following this with proper treatment she apparently recovered and made a "hand" in cultivating the crop, in October following, the swelling returned as bad as in the first attack and on November 12th. I visited her and as she begged me to do so, I again operated, removing fully as much fluid as I did the first operation, after which her recovery was permanent, there having been no return of the disease up to this time. On May 18th. 1911 was called to see the man's wife found her with a severe case of pellagra of several weeks standing, on June 10th. while visiting the mother, the daughter called my attention to her own condition, upon examination, I found she had pellagra, but in much more mild form than the mother, both suffered a great deal until cool weather when the disease disappeared and they apparently recovered, on December 30th. 1911 I was called to see the girl, who had married since I last saw her, but was living near the parents. I found her with pneumonia, she recovered without serious trouble, while attending her I was called to see her father and was greatly shocked and surprised to find him with a severe pulmonary hemorrhage and in the last stage of consumption, I was never able to do more than partially check the hemorrhage and he died in a day or two after my one visit, as I said the two important features connected with these cases are their comparative rarity as well as the fact they all occurred in a family of three persons and in a period of less than three years, despite the severity of the several diseases two members of the family live and are apparently in good health.

At the risk of tresspassing upon your time and patience, I will report another case, one that has given me a great deal of trouble and caused me a great deal of anxiety, for several years past my daughter, a woman grown, has suffered with more or less pain in the right side, in the region of the liver and gall bladder while the pain came in paroxysms, there was nearly always a feeling of discomfort in this locality, with occasional pains under the right shoulder, I diagnosed gall bladder disease and treated her for this, with only partial success, as the pains were relieved for only short intervals during all the time since she was first taken, there was never any jaundice, I sent her to some of the best physicians in Memphis and went with her to Chicago, where she was examined and treated for three weeks,

by two men who make a specialty of diseases of the liver and gall bladder, each and every man that examined her pronounced the trouble in the gall bladder, no one of them said gall stones, at the earnest solicitation of my family and friends outside the profession, I sent her to Memphis to an osteopath, a man who stands among the best in his school, his diagnosis was "Pyloric Ulcer," final results proved him very nearly correct, finally in desperation and almost in despair I sent her to Mayo Bros., I wrote them a history of the case and asked for a diagnosis, prognosis and treatment, they kept her under observation, while using all the diagnostic tests, from March 1st. to March 9th., Dr. W. J. Mayo, said, gall bladder disease, Dr. Graham, a brother-in-law of Dr. Mayo, and a stomach specialist, said, "gastric ulcer," on March 9th. Dr. Mayo did an exploratory operation, his findings I can best describe by quoting from his letter written me after the operation, he writes as follows: "Your daughter was operated on this morning, she had an ulcer of the duodenum just below the pylorus and extending downward an inch and a half, involving its entire circumference and most markedly the anterior wall, there was evidence of a recent peritonitis and the ulcer would have perforated had it not been for an adhesion to the gall bladder and gastro-hepatic omentum which covered it over, we surrounded the ulcer on the anterior surface with two circular sutures of linen and turned it completely into the cavity of the duodenum and then did a posterior gastro-enterostomy, unless something unforeseen occurs she should make a good recovery." Reports from her received daily, say she had a normal pulse and temperature after the third day, sat up in a chair on the sixth day and left the hospital on the twelfth day, here is a case that baffled the best diagnostic skill in the profession, one that can justly be termed a *masked* case, for authorities tell us the symptoms of duodenal ulcer, gastric ulcer and gall bladder disease are so nearly identical and the organs so close together a distinctive diagnosis is nearly or quite impossible without surgical interference and this is rarely done until perforation or hemorrhage occurs when in fifty per cent. of cases it is too late. I believe in this case the difference of opinion among the doctors which almost forced an exploratory operation was Providential, as otherwise the true condition might not have been discovered until too late. In conclusion I will say, to some it may appear as an evidence of bad taste and a lack of delicacy, for one to report cases occurring in their own family, and perhaps it is,

I will say in apology, that I have been engaged in the active practice of medicine since 1871 and in all these years the profession of medicine, its advancement and upbuilding has been to me as something almost sacred and my life-work, hence if by reporting this case I can help some one's work in the profession I will cheerfully bear any censure for my seeming lack of delicacy.

Society Proceedings.

Clay-Lowndes-Oktibbeha Medical Society met at Artesia June 27th, holding morning and afternoon sessions with a barbecue, a band concert and a ball game between the two. The morning session was open to the public with papers on oral prophylaxis and public sanitation by J. S. Hill and Jno. McElroy. In the afternoon there were papers by W. D. Hubbard, J. W. Lipscomb, P. R. Brown, W. F. Richards and F. D. Smythe and an address by W. S. Leathers.

Edward Lehmberg.

Kemper County Medical Society was organized July 1st. Dr. D. C. McLean of DeKalb is secretary.

Leake County Medical Society was organized July 1st., Dr. Isaac Chadwick of Carthage president and Dr. J. L. Parks of Carthage R.F.D. No. 3 secretary.

Tri-County Medical Society meets at Crystal Springs, Miss., July 30th., 2 to 4 P. M., under the auspices of the Mississippi Chautauqua Assembly. 1.—The Louisiana Plan, Dr. Oscar Dowling, president Louisiana State Board of Health; 2.—Objects and Aims of the Mississippi State Board of Health, Dr. W. S. Leathers, Director Department Public Health, Mississippi; 3—Pure Food, Dr. W. H. Rowan, Field Inspector, Department Public Health, Mississippi; 4—Legislation Along Sanitary Lines, Dr. S. W. Glass, President Mississippi State Medical Association; 5—Recent Studies in Malaria, Dr. C. C. Bass, Professor Clinical Bacteriology, Tulane.

MISSISSIPPI MEDICAL MONTHLY.

E. F. HOWARD B.S., M.D., Editor and Publisher.

S. MYERS M.D., Business Manager.

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OFFICIAL ORGAN OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION AND ITS COMPONENT SOCIETIES.

SUBSCRIPTION ONE DOLLAR PER ANNUM.

The State Board of Health held its semi-annual examination for license June 4th. and 5th. and passed favorably on the papers of forty-three applicants. The recently enacted practice act was the cause of the number of applicants being about half of the usual allowance, none but graduates being now admitted to the examination.

The editor of the *Monthly* being in Jackson on a little matter of worldly business dropped in on G. S. Bryan & Co. to pass the time of day and viewed with much interest the proceedings of the Board. The Jackson papers stated that the "Secretary of the State Medical Association" was in attendance but we wish to correct this statement; the secretary stayed at home. The Association was represented by the president, who is big enough, in every way, to do all the representing needed.

During his visit, the editor was showed the "star" paper of the examination and was so impressed thereby that he borrowed it in order that others might profit by it, and it is reproduced *verbatim*. It was an awful job getting it into print but it has been done and we are very proud of the job, no matter whether the author shares our feeling or not.

Be it known that this paper was written in all seriousness by a graduate (Heaven, help us!) of an Illinois medical college and was turned in to the examining board as proof of the fact that the man writing it was qualified to practice medicine in Mississippi! It is not a joke, though it would be if it were not pitiful.

A word of explanation is needed. The questions were given out in typewritten form and the applicant was to copy each question on his paper and then write the answer. As this applicant didn't have sense enough to even copy the questions

correctly, we have given, first, the question as given out by the Board; second, the applicant's copy; and third, the answer. It will be noted that in some instances he didn't even try to copy the question. The weird, archaic handwriting was difficult to interpret but we have had nine years' experience in deciphering illegible chirography and can assure our readers that we have this masterpiece in correct form.

When such cattle as this are turned out of the medical schools it is time to call a halt. It can be done. Our practice act reads that only a graduate of a "reputable medical college" can apply for license. In the name of the people of Mississippi, for the sake of the honor of our profession, in gratitude to the legislature that passed the law and certainly did not expect to put up with such a state of affairs, we enter a motion to the effect that, if it has not already done so, the Board declare this college not reputable and we request that every person, physician or layman, who reads this will second our motion.

SUBJECT—Surgera.

Question 1. Name the various means and methods that may be used to assist in the diagnosis of abdominal diseases.

the various means and methods to Diagnose abdomnal Desese. test the nerves of the abdomnal walls by Looking in mouth taken tempeture and a external ,examination of the abdoman.

Question 2. Mention the indications for intravenous saline infusion and describe the procedure.

the Indication Intraveneous Saline Infusion.

the Intervenious Saline Infusion Indication from fevors Nervious Empulce over Worked.

Question 3. Describe Tracheotomy and Intubation, and state when each is indicated.

Trachectomy and Intrabation When each is Indicated.

Trachectomy and intrebation is when costipation has gotten holt on the person or parsons and Digesting is poor. Sour Stomach. Sick Headache and congesting of the Bowels.

Question 4. Name the various causes of peritonitis and give treatment.

Various causes of Peritonitis.

peritonitis is cause from alcoholic excess Strains in work or walking Jumping. Digitalis. nux Vomica. Strychnin. nitro glycerin.

Question 5. Define Cholecystotomy, Cholecystectomy, Cholecystojejunostomy, Cholecystotostomy, and give general indications for the performance of each.

cholocystomy cholecystotetmy

Define Cholocystomy cholocytotetmy this is found in Regeon of poupart Ligamen an Incission Should be made Just be Low the abdomanal Ring and this much turn back then With a Little Deep Incesion We come to Hunter canal whare the opperation can be performed. to be carfull not to Injure the big Internal Sciatic nerve as it can be seen.

QUESTION 6. Give full list of post-operative complications and select three for treatment.

Give List post operation complications

List of operation with complication. Styloid tuma. Ingurnal hernia. tuma of the tissue. abses of Vains. treatment Hernia. abses. tuma.

QUESTION 7. Describe two methods of administering salvarsan.

Describe two methods of administrating Salverson

Salverson can be Injected or it can be Rub, in the Skin, with a Little Pressur.

QUESTION 8. Ask what you regard a hard question, and write your answer.

ask what you would call a hard question

What I would Regard a hard question—cholocistotetomy. my answer would be that this is Located around Hunters canal.

SUBJECT—PATHOLOGY.

QUESTION 1. What is the histological difference between Carcinoma and Sarcoma?

What the Difference between caroinoma and Sarcoma

the Diffrence between carsonoma Sarcoma Sarcoma origen in the tissue and in the blood vessels. and carsonoma origen in the Intestines.

QUESTION 2. What pathological changes are found in Addison's Disease?

the Pathology the changes in addeson Deses

the pathoiagical changes in Addison Deseases is a Swelling of the Joints Simler to Drpsy With Pneumonea affection Rheumacisim Pains.

QUESTION 3. What valve is most commonly involved in Endocarditis? And the usual causative micro-organism?

the Valves that mostly Involves in Endocarditis

the Valves that is most Involve in Endocarditis is the mitel Valve Vantrictular Pneumonia is the most common Desease for that organ and Pericoditis

QUESTION 4. Name the organism most frequently associated with acute pneumonia, and give the pathological changes in lung tissue during progress of this disease.

the organisum that is most associated pneumonia is the Lungs.

the Lungs is more secepted to pneumonia than any other organ the Lung and tissue Increase in Size on act of the flash that accumelate thair Durin Deseases.

QUESTION 5. In what disease do you find ulceration of the intestines?

in What Deasies Do you fine ulceration of the Intestin

Deseases that or found in the Intestins. malaria, colra, Small Pock. Summer complaints.—and constepation

QUESTION 6. What is the difference between Hematuria and Hemoglobinuria, and give causes of each?

What is the Diffrence in hemoturahr and hemoglobunuria

hematuralrs is from the overa hemoglobinurahr is from the vains. One is a white mucouse and the other a not but is thick nearly transParin the or cose by a Strain of Some Kind.

QUESTION 7. What is Uremia, and in what classes of cases is it seen?

what is Urema and in what class of cases is it found or seen
Urania is found in the or See in Gonorrhor or Syphillis

QUESTION 8. Name several conditions that may cause dropsical effusion in the abdomen or lower extremities.

name Several Condition that may cause Dropsical condition in the abdomanal and Lowe Extremeties
Rheumatism Syphillis Siphillis pneumonia

SUBJECT—MATERIA MEDICA.

QUESTION 1. (a) Give methods of administering drugs. (b) Give a rule for dosage of children. (c) How many grains in one gram. (d) Define Alkaloids, Decoctions, Infusions, Spiritus, Aquae, Misturae. (e) Define and give example—Anaphrodisiac, Anthelmintic, Carminative, Cholagogue, Myotic, Oxytoxic.

Give six minums of administrated drug for a child how many grains in one Gram.

the Dosage for a child Should be Devided by the age Say at one dram for a grown person by 1-12 or 1-24 of the hole for a child——12 Grains to the Grame alkaloid Decoction eome pose of carbonate citratis—aprodiser Salts peper Vingar mustard Ruini Blue mass mercuric Salt Rochel Epsom.

QUESTION 2. (a) Give composition of Pilula Cathartica Composita and amount of each ingredient to appear. (b) Pulvis Effervescens Compositus. (c) Dovers Powders.

Give Pills eomposition compound eathartie—Effervasoin eompound or composition.

Jalapa gr. ii Calomel gr. ii Soda Carbonate gr. ii composition Pulverisi Effervasces Soda biearbonate acidi citrate.

QUESTION 3. Give technical name of Green Vitriol, White Precipitate, White Vitriol, Oil of Vitriol, Tartar Emetic, Rochelle Salts, Turpeth Mineral, Citrine Ointment.

Give taehnicle names for Green Veritoral White tarter Emetic
turpenthin or Rossum, croton oil oil of cresota Rochel salts made from juces of Lime or Lemon Starch.

QUESTION 4. Give the common name Oleum Theobromae, Ulmus, Anthemis, Taraxacum, Triticum, Oleum Ricini.

Give common names for oil of theobroma—oil ricini.

The common names for oil ricini castor oil. and oil of theobroma is fix oil from Lards. Dandelion is eommon name for Taraxaca

QUESTION 5. Give antidotes for acute poisoning from Opium, Phosphorus, Nitrate of Silver, Sulphate of Strychnine, Carbolic Acid, Arsenic, Bichloride of Mercury.

Give antedote for opium Poison Phosphorus Silver Nitrate Strychnine Carbolic Acid, and Bichloride of Mercury.

acute poison by opium phosporat Silver nitrate-mustard in water to Drink coffee Lime water artificial Resporation and an Injection of apomorphin has Don good cold application helps as Well as hot one.

Question 6. Give doses of following drugs:—Plumbi Acetas, Liquor Potassii Arsenitis, Oleum Terebinthinae, Sulphate of Atropine.

Give Dosages of Plumbi sub acetat Liq potash arsenitis oil of Terpenthine Sulphus atropine

Dose of atropin gr. 1-200 Liqer asonitis Drop from 1 to 3 as a dose—the Terpenthim oil is from 3 to 5 Drop for a Dose. Plumbi Subacetate Dose 1 to 5 gr. Rearley give over 3 Gr.

Question 7. Name the cathartic that acts within the shortest time. Name Salt of Quinine most soluble in water. Give different varieties of Aloe. Give the officinal Alum.

name the cathartic that work the quickest.

Castor oil blumas, Calomal. With Jalapa. Epsom Salts Sulphate, soluble in water——crude and commercial alum—also only one that is use in medicine.

Question 8. Give physiological effects of opium.

Give physiology effects of opimn

at first opium Stimulates but in a Short while you be gain to feel Sleepy, Delirum and to Coma or profound Sleep——

SUBJECT—Obstetric.

Question 1. Give fully your course of procedure after being engaged by a woman to attend her confinement, thinking that she had advanced about three months in her pregnancy.

Give fully the course you would Procede in Pregnanci.

I look after the care of the food for the mother proper Exercize Exammen to See if She Was in Advance Stages take test for Urin Pay attention that She Do not Disarrange my Plans and in Struction I have given her.

Question 2. What important emergencies may arise between the sixth month of pregnancy and parturition, and how would you meet them?

Emportant which may a Rise of Six month of Pregnance the Falling of the Fetus from it bed hemorrhea Sick Stomach headachs in hemorrhr Give Ergit. Sick Stomach give Practely nothing but in Fetus Falling out of it bed it Should be Replace and a Sospensery worn to keep it in Place.

Question 3. What constitute the dangers of an incomplete abortion? What are the symptoms? Give management of the trouble.

Give Encomplete abotion and thair Symptoms

the Symptoms of abortion is hemorroh pain Some times Swelling unconcius. Stop the hemorrhage put Pation at Rest in bed to keep quiert.

Question 4. Give fully the modern preliminary preparations for cases of labor regarding physician, nurse and patient.

the arangemts for a Labor case

arrangements for Labor case Plenty of hot water in house and assistin at hand Ergot chloroform bandages Instrement Sterlize and Ready for use if neaded

Question 5. Give definition and symptoms of ectopic pregnancy, and how would you manage the same.

Give Definteon and Defin Ectopic Pregnancy.

Ectopic pregnency is is found to posteria pelvis in Stead of more an-

teria. the pation must be keep more in an Incumbrand Position to aid in getting the fetus turn aRound to the proper Place

QUESTION 6. Define prolapse of the Funis. Give causes, dangers and management.

Defin prolaps of the fundus

the prolaps of fundus case by Standing in one Position two long or a fall the prolaps of fundus case by Standing in one Position too long or for Some time rrom Laying in one Position two Long. pation is to be Put at Rest.

QUESTION 7. Define sub-involution. Give symptoms, causes and management.

Defin Sub Invulation

Sub Involation Suffering with Sharp abdomanal pain from Some food or Drink that has been taken not necessety to be fatal a good Purgative Some time Give the Best Result.

QUESTION 8. Give causes, symptoms, preventive treatment, also curative treatment and prognosis of ophthalmia neonatorum.

ophthalmic hoonatorum

ophthalmac Hoonatornm the causes is of poor nutriction Look as thair was no blood in vains with Good care Rest may Recover. to treat the blood Keep them in Good condition will plenty food and Rest Keep the System clean—

SUBJECT—PHYSIOLOGY.

QUESTION 1. Define reflex action and discuss fully the "knee jerk" as a diagnostic sign.

Defin Refexaction of the Knee Jerks.

Reflex the Knee is cause by Long Standing, the Diagnosess for Knee Jecks is Stiffness Sweeling and very Senctive to touch

QUESTION 2. Locate the respiratory center and state the chief cause of the automatic activity of this center throughout life.

Locate the Resparation center

Resparation centers in the Lungs and the pulceation of the heart With the blood Sopply causes this to continnu throgh Life.

QUESTION 3. Define Metabolism. For what general purposes are, (a) Proteids, (b) Carbohydrates and (c) Fats utilized in this process?

Defin metabolism

Hemoglobin carbo Hydrade fats are Stored up for Sugar ura Sweat and feede Stuff.

QUESTION 4. Describe red blood corpuscles as to (a) origin and fate, (b) form, (c) size, (d) position in the blood stream, (e) manner of passage through the capillaries and (f) principal function.

Discribe Red blood Corpooscles.

the is Sompthing Like 25000 to Sueh Size ean not be Seen With the naked Eye. the passes thrught the capiliarus at the Rates of 10000 to the minute.

Question 5. What is the difference between glandular secretion and execretion: give examples of each.

What is the Diffrence between Excretion and Glandeler Excretion.

Glandiler Excretion comes from the Glands With an acid Reaction. Excretion has and alkaloid Reaction.

Question 6. Define Myopia and Hypermetropia, and give usual cause and manner of correcting each.

Difine myopia Extropia and causes of each

myopia is cause by Some Obstruction of the Thorax may be corrected by the use of Lectricity or hot application. Some tim cold one Does good.

Question 7. What are the Myogenic and Neurogenic theories of heart-beat?

What air the hyogenic—Hourgenic heart beats.

myoganic heart beats can be felt plainly at the Radial—neurogonic heart Beats is felt Plainly over the apex at the Rist or at the top of clavicle.

Question 8. What glands give rise to the so-called "internal secretions" and which of these glands contain substances of therapentic value?

What Glands give Rise to Internal Secretin—and Glands contain

the Heart is the Interal Corection the Liver the Splens. the Kidney the Liver with it bile.

SUBJECT—Hygiene.

Question 1. Define the terms "Hygiene," "Epidemic," "Pandemic," "Endemic," "Contagious" and "Infectious."

Difin terme Hygin Eppiconda conteges and Disenfection colra yellow. Fevors Scarlet Fevors bubonic plig measle

Question 2. What insects convey disease to man? Name each disease and give method of prevention of two most important.

What Insect convay Desseses and Each Desseses

the Fly—musqueter. the Fly Spreads Scarlet fover. measle. musqnitor Spreads Yellow Fevor. boiled Water. to Drank. Screne. to the window. and be carefulle about what you Eat

Question 3. Give hygienic management of a case of tuberculosis.

Give Hygenic managemnt of a case of tuburculoses

Plenty of fresh air Sun Shine And carfulle about the Diet and the bedding and Waring appels Should be Keep in a clean condition.

Question 4. What is the chemical composition of air? How many cubic feet per hour required for each individual? Discuss ventilation of the home.

What is the chemicle Composition of air and how many cubic feet per hour.

Composition of air is Light and Penetrating 9.00 nine cubic feet per Hour in Room 10 x 12

Question 5. How would you conduct the inspection of the children of a public school and what would you expect to result from your inspection?

how would you conduct the Inspection of a School house
have the School well ventilated Plenty of Good Drinking water and all Drains Keep in a Sanaterial condition—the children would be Keep healthy and free from contegis Dissese

QUESTION 6. Build sanitary privy and tell what sanitary effect you expect from its use.

Define Sanitery privey what benefit you would Expect
I Would Exspect to Receive no Smell from it—or order of any Kind in this healthy condition.

QUESTION 7. What constitutes pure drinking water? What does excess of chlorine in water signify? Give method of purifying water.

What Constitute pure Drinking Water
Runing or Spring Water Boiling Water and Lime Purifey it. chlorin hase agass in it and when it has Excess to Water it is Poison not fit for Drinking.

QUESTION 8. Discuss the proper disinfection and fumigation of railway trains, depots, schools, churches and public buildings.

the Proper Desenfection and Fumigation of Rail Way
Remove Drinking Cup from Public Places Keep the toilet in proper condition Use Sulphur—Formaldehide as Fumigating carbolic acid in Solution Lysol in Drains &c for Dissenfection

SUBJECT—ANATOMY.

QUESTION 1. Name essential parts of a vertebra and differentiate between cervical, dorsal and lumbar vertebrae.

the Servical vertebra has a more Promint Fossa on the 7t hand no clinci Fosset. The Dorsal and Lumbr hase a Large body.

QUESTION 2. Describe the knee joint.

the Knew Joints is a ball and Socit Shape at thair union.

This line was scratched and the following added on another page:

the Knea Joints is a Ball and Socket Shape at the union.

QUESTION 3. Name pectoral group of muscles; give origin, insertion and nerve supply.

Muscles origen is the Latisnms Dorsi inSurtion at the inter Section of the abdomanal muscle Sciatic Internal popliteal

The applicant had scratched this answer and added the following on another page:

the muscle origen at the Latissmos Dorsi Insertion of abdomanal muscles and Visserus

QUESTION 4. Tell where femoral artery begins and ends and name branches.

femeral artery began in the abdomal Plikus Ends in the Poplitiel Intnal exteral bicepts.

On another page:

abdomanal ortera beginin in the abdomanal Plxis Ends in the Popilar teal

QUESTION 5. Locate the pancreas; give shape, size, weight.

Pancreasae Located Just be Lowe the Liver and of oblong shape Weight 1½ Lbs Size heart

On another page:

Just blowe the Liver weigh 1½ pound or about 28 oz of obling Shape

QUESTION 6. Explain difference between femoral and ingninal hernia and name coverings of an oblique inguinal hernia from within out.

Femoral hernia ar more easy to Locate then Ingernal on act of it Striated Tissue it is Easer to Locate

On another page:

Femoral Hurni or more Easey to Reach then Ingernal and Ingernal or coveried with Striated tissue

QUESTION 7. Number, name and tell how cranial nerves get out of skull.

31 pair neumogastric efferant afferant meningeal all passes thrught Foramn magnum

QUESTION 8. Name and locate the processes of duramater of the brain.

the Duramater Located in the Pont the ar a mucauser matter.

The applicant had added on another page without scratching his original anwser:

the Dura matter Located Just be Lowe the Ponds—of back of the Skull.

SUBJECT—CHEMISTRY.

QUESTION 1. State the physical and chemical properties of carbon dioxide and name three different processes by which it is generated in nature.

cobon dioxide Generated throght mouth and nostral by Hydrogen oxigen and Sulphur

QUESTION 2. Complete the following equation: $Ba\ O_2 + S_2\ Ho_4 = ?$

Bromides and oxigen—Hydrogen

The applicant added on another page:

"Subject Chemistry, Question 2. Bromides, Hydrogen and Oxygen.

QUESTION 3. Name three and describe in detail one test for glycosuria.

Sulphur oxygen Hydrochlorate acid nitric methylen

This was duplicated on another page except that "acid" was put between the last two words.

QUESTION 4. Give the chemical formula for each of the following: (a) baking soda, (b) zinc chloride, (c) Epsom salts, (d) potassium permanganate, (e) mercuric chloride.

K. m. mu c. h. zn. c—S. C.

QUESTION 5. What is the difference between sulphates, sulphites and sulphides?

The diffrenc the Sulphates is not So much Emportant as the other.

On another page:

the Sulphate is more use than the Sulphite or Sulphides and is more Emportant in medicine.

QUESTION 6. Describe mercury and give a test that will distinguish mercurous from mercuric chloride.

Solution of the Chloride in methylene blue Co With nitric acid give a blue collor

On another page:

the chlorid in Solution with methylen blue Co nitric acid give a blue collor

QUESTION 7. Write equation showing the reaction when a solution of mercuric chloride and potassium iodide are brought together.

makes a White Solution With the mercury Flotin at bottom make a Effervassen appear

On another page:

When a Solution of muricon chloride and Potash Iodide is mixed the mercurie Sinks to the bottom on agetatin it is Effervassen

QUESTION 8. Give the reaction for normal urine; tell how you determine reaction and give test for albuminuria.

normal urine is clean yellow Transparen layor a few Drop nitric acid in Test tube heated will give you heavey albumn Test which Settle at the bottom of the tube if albumn is Present

On another page:

an normal urin has a clean Transparent coller but when albumn is present it has a heavy yellowish collor When heated it has Sedement at the bottom of test tubes.

Book Reviews.

INTERNATIONAL CLINICS. A quarterly Of Illustrated Clinical Lectures And Especially Prepared Original Articles. Vol. II. Series 22. 1912. Edited by H. W. Cattell A.M., M.D., Philadelphia. J. B. Lippincott Co., Philadelphia. Price $2.00.

An anesthesia symposium, consisting of a dozen papers by experts in their line, is the most prominent feature of the issue under consideration. Besides this there are some readable articles on sunstroke, headache, food and other seasonable and rational subjects. Of interest in consideration of the question "whither are we drifting" will be found an article on the national insurance act of the united kingdom.

E. F. HOWARD.

THE PRACTICAL MEDICINE SERIES, Vol. III, The Eye, Ear, Nose and Throat, edited by Casey A. Wood, C.M., M.D., D.C.L. Albert H. Andrews M.D., Gustavus P. Head M.D. The Year Book Publishers, Chicago, Ill. Price $1.25.

This small book presents a review of the more important papers of the year in the form of abstracts from the original articles. The field covered is a wide one and the work has been well done by the authors. The book is well worth the price asked for it to any physician and should be in the hands of all doing special work.

M. H. BELL.

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*SALVARSAN—ITS ADMINISTRATION.

DON C. LA VERNE Ph. M., M.D.,

SENATOBIA.

Dimethyldiamedoarsenobenzol, salvarsan or, as it is popularly called, 606, fortunately was well tried by Ehrlich and his co-workers previous to January 1st, 1911, when it was put into the hands of the general practitioner.

Because of the destructive affect it has upon the spirocheta pallida it has ben tried in almost every known parasitic disease, as well as many others the causes of which are unknown.

Salvarsan is not a cure-all; too much has been expected of it outside of what its discoverer intended it to do.

It has been well tried in malaria and pellagra, two diseases with which we in this section are much interested, and while some few cases of tertian malaria have been reported as benefited, the quartan and æstivo-autumnal types have not been disturbed.

Martin of Hot Springs and Crowell of Charlotte, N. C., seemingly working independently of each other with salvarsan in pellagra, think they have discovered a ten-day cycle for the theoretical pellagra microbe, and on this theory they have been giving 0.6 grams of salvarsan intravenously to their pellagra patients every ten days. Martin reports a number of cures, I don't remember how many, and Crowell reports fourteen. The work of these men must be confirmed by many others before it can be said that we have a cure for pellagra in salvarsan. The mass of experimental evidence coming from workers with salvarsan among pellagrins shows but little benefit to the sufferers.

Among the diseases other than syphilis in which it has been given with more or less success are Vincent's angina, pernicious anemia, Gambian fever, relapsing fever and frambesia.

The spirochete Obermeier in relapsing fever succumbs to the action of salvarsan as readily as does the spirocheta pal-

*Read before the Tate County Medical Society.

lida. The trypanosomes of Gambian fever, or African sleeping sickness, likewise appear to be quickly destroyed by it as well as the spirochete pertenuis of yaws, or frambesia. With these latter conditions, however, we have but little to do, for they are rarely found in the United States and then only along the sea-coast where they have been introduced from foreign countries.

This brings us to the use of salvarsan in the only disease in which it is of much practical benefit in our practice and here it would have a great field of usefulness were it not for the care that must be used in its administration and the prohibitive expense for the same when we consider the class who need it most—the negroes.

The negroes and some whites cannot be induced to keep up the long treatment necessary to cure syphilis with iodide of potash and mercury. If we had some means of administering salvarsan other than intravenously, with as little inconvenience to the patient as this method when properly carried out subjects him to, or if by some means the tedious methods of sterilization and preparation could be done away with without danger to the patient, or the cost of the treatment could be reduced and yet afford the physician sufficient recompense for his time and trouble, there would be a great field for this work here, for the treatment of syphilis with salvarsan and mercury will, no doubt, do in three months what mercury alone would take three years to do.

Keidel and Garaghty of Baltimore report seventy cases in the primary stage with chancres of from one to three weeks duration in which a single intravenous dose of salvarsan was given and the Wasserman reactions were negative after five months. The literature is teeming with similar reports and though I have never had the opportunity of giving salvarsan in the early primary stage of syphilis I am satisfied that if early excision of the primary lesion is done and salvarsan is given in sufficient dosage, the patient will get well without further treatment.

In active secondary syphilis, and these are the cases with which I have had most to do, the lesions and clinical manifestations have promptly disappeared following treatment, and a Wasserman reaction is often negative. Recurrences, however, are altogether too frequent and these are the cases in which the dose must be repeated and the treatment combined with mercury.

In the experience of all workers with this drug in late recurring secondary and tertiary syphilis it has been well shown that salvarsan alone has been unable to accomplish what salvarsan and mercury together will do.

In the administration of the drug intravenously, and the best men after Ehrlich's suggestion are now using no other method, there are many things we must keep constantly in mind. We must remember that it is an arsenical preparation, and that there is enough arsenic in it which if uncombined, would probably destroy the life of the patient. Hence we should be careful not to give it in conjunction with other drugs which might change it chemically and let loose a lethal dose of arsenic.

We should not give it after such drugs as atoxyl and arsacetin have been given.

A thorough study of the patient's condition in order to avoid accidents, with special attention to the heart, lungs and kidneys, should be made, but where the lesion is slight and syphilitic in origin, it may often be given with safety even in these cases. I have given it in two cases in which I have found the urine loaded with albumin and casts, but knowing the condition to be due to syphilis alone I did not hesitate and in a few days the urine was normal.

It should not be given in advanced cases of tabes, general paresis and nerve syphilis affecting vital centers. It should not be given to debilitated persons unless the condition is due to syphilis.

Sudden death has occurred from a ruptured aneurism and from the washing of a blood clot from the lumen of the needle where it had coagulated, into the blood stream. It has also occurred in unrecognized meningitis and brain tumors. Other unpleasant accidents have happened owing to its careless administration.

All authorities on the administration of salvarsan, including Ehrlich, tell us that our patient should not be given this treatment without the advantages a hospital affords. I have not found this necessary in properly selected cases. My system is: after giving the injection to put the patient to bed for five or six hours. If after this time there are no symptoms which contraindicate it I put him in my buggy and carry him out in town to where he may be staying, and put him to bed and have him remain in bed for three days. If all is well then I let him get up and go about his regular affairs, cautioning him to be

moderate in his exercise and diet for a week. I have had no bad results and I believe that after five or six hours rest the ride of a few blocks does no harm.

I shall say nothing concerning the technique of intra-muscular and subcutaneous injections any more than to say I have tried them and I don't like the result. It is no joke to have a patient howling with a lump on his back or in his gluteal region which may or may not be absorbed. While trouble of this kind does not occur often, it occurs frequently enough in the hands of the best men so that they have mostly abandoned the method.

As to the intravenous method there are several, and I know of none of the writers on the subject who now follow the directions given with the package. I consider it crude and not at all definite.

To begin with we must provide ourselves with the necessary equipment, sufficient glassware, distilled water, litmus paper, filter paper and a small sterilizer. Everything must be sterilized as for a major surgical operation, including the distilled water, litmus and filter papers. The field of operation too, must not be neglected under the misapprehension that this is a simple procedure. While there are several methods for preparing the drug for administration all agree on the necessity for strict asepsis.

Lesser's Method: Take a graduated glass cylinder with a ground glass stopper in which there are about a dozen glass pearls to assist in mixing. Add 606 salt: immediately add fifteen cc. of warm sterile water; shake vigorously until every particle of the salt is dissolved; add two cc. normal sodium hydrate solution—a precipitate occurs. Then add sodium hydrate solution in small quantities, shaking vigorously after each addition until the solution clears. This should be neutral in reaction. If on testing with sterile litmus paper it is still acid, add more sodium hydrate solution; if alkaline, add fifteen per cent. acetic acid until neutral.

Schreiber's Method: Into a graduate holding 250 cc. put the required dose of 606 and mix thoroughly until it clears. Add chemically pure normal salt solution to 100 cc. then add 0.1 gram of 606, 0.7 grams of normal sodium hydrate solution and mix thoroughly until the precipitate is redissolved. If after thorough mixing the solution is not clear, add a few drops of sodium hydrate solution to make it clear, and then add sufficient sterile normal salt solution to make 250 cc.

The fluid used must be at body temperature.

Schreiber uses the Cassel syringe and apparatus, and says that by its use there is less danger from air emboli.

The solution should be used within twenty minutes after mixing, for chemical change is likely to take place owing to exposure to light and air.

My own method differs from Lesser's only in that I do away with the glass beads and filter my solution while hot, using sterile filter papers. I found the beads not to be necessary if water is put into the mixing jar before the salt.

In order to be sure of having the needle in the vein some operators still think it is best to open the vein and tie the needle in place. I have found this necessary only in one case; this was one in which there was so much fat the vein could not be outlined even after a tourniquet had been applied. The lumen of the needle should be of such diameter as to take about ten minutes time for the solution to run in. Pain at the point of the shoulder has been felt when the solution was entering too rapidly.

If the needle is not in the vein but in the cellular tissue surrounding it, sloughing is sure to occur and the pain is great.

The after affect of the intravenous method is most gratifying to one who has previously used the subcutaneous or intramuscular injections.

There is frequently nausea, vomiting and diarrhœa within an hour, due to the endotoxins liberated by the killed spirochetæ. Temperature from 100 to 103° F. is present from the same cause, lasting sometimes a day or two.

Martin of Hot Springs says that he now uses 606 for the purpose of diagnosing syphilis. That if there is no reaction from the drug given intravenously there is no syphilis. He was not the first to make this observation. If the technique of administration is right it may be given to a healthy person with absolutely no reaction as shown by Montgomery and others.

The Hexheimer reaction I have not observed in any of my cases. It is a rash occurring after a day or two, found most often on the trunk. I have observed, however, a phenomenon first mentioned by Iwaschenzow which suggests anaphylaxis. He reported fifteen such cases occurring in patients to whom the second injection had been given. In his cases there was a swelling of the lips and tongue, lasting from several minutes to one-half hour after the injection. My case was also one to whom I had given the second intravenous injection, the first

having been given about two months previously. My attention was called to the swollen lips and the patient said he had difficulty in deglutition. Examination showed the tongue and soft palate swollen. The condition subsided without treatment in an hour, to my great relief as well as to that of the patient.

I have found arsenic in the urine (using Aberlin's test) from twenty-four hours to one week after intravenous injection. It has been found as late as three weeks.

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*SOME PUZZLING THORACIC SYMPTOMS IN ACUTE MALARIA.

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DUBLIN.

To repeat the old adage "Money is the root of all evil" only serves to partially remind us, the inhabitants of the South, that we may add another adage, more appropriate to our section: "Malaria is one of the greatest curses to humanity." Like a thief in the night it frequently lies dormant in the system until it has manufactured enough warriors (parasites) to win the battle, as we are all aware. We have very few specifics in medicine, but among this limited number is included one for this great enemy to mankind, yet in spite of this fact it frequently comes from the battlefield wearing the crown of a victor.

I wish to briefly discuss some thoracic symptoms that have come under my observation. I have at various times been called upon to treat patients suffering from acute malarial attacks, with characteristic paroxysms and fever curve, with which all are familiar, and in addition I would find the patient suffering from a cough, sometimes dry, sometimes with copious muco-purulent expectoration, occasionally blood-streaked, and

*Read before the Clarksdale and Six Counties Medical Society

on auscultation I would find sub-crepitant rales disseminated or localized over one or both lungs. I would find percussion note normal; liver and spleen enlarged; tongue large, flabby and coated, characteristic of malarial infection.

Mannaberg, in his work on malaria, reports a case who lived in a malarial district who repeatedly manifested, with a tertian intermittent, so intense an apparent bronchitis, influenza, etc., that the physicians were always deceived in their diagnoses until the further course, characterized by typical paroxysms and prompt reaction to quinine, placed the diagnoses beyond doubt. Similar observations have been made by other writers.

Hineman frequently saw in Vera Cruz coryza, bronchitis, marked dyspnoea, etc., go hand in hand with acute malarial attacks. Grasset has collected in his thesis several cases of this kind. It has been shown by Bignami that in pernicious forms of malaria the mucous membrane of the gastro-intestinal canal will show microscopically numerous punctiform hemorrhages. The capillaries of the mucous membrane may be crowded and their lumen obstructed with parasites which may be contained within red blood corpuscles or may exist free. These thromboses result in necrosis of the epithelium of the mucous membrane with superficial ulceration.

Barker, *Johns Hopkins Hospital Report*, reports a case in which the capillaries of the mucous membrane of the gastro-intestinal tract were so blocked with parasites that small circumscribed necroses of mucosa resulted.

If this is true of the gastro-intestinal tract, it is certain that similar conditions can exist in the lungs. Sajous in his writings on malaria says: "In many cases areas of broncho-pneumonia or infarctions are to be observed and it is noteworthy that the areas of broncho-pneumonia do not as a rule show the presence of pigment microscopically. The capillaries of the alveoli are found to be filled with infected blood corpuscles, the capillary endothelium frequently contains pigment although the large number of phagocytes contained within the alveolar capillaries may lead to necrosis."

I have recently dismissed a case in which, in a severe malarial attack, the characteristic thoracic symptoms, as previously described, were present for six days. This patient's temperature was from 101 to 103° F., respiration from 30 to 60 per minute, percussion note normal, sub-crepitant rales over both lungs.

The question I wish to ask is this: are all cases pneumonia, bronchitis or la grippe that are so diagnosed? In my humble opinion I will say emphatically "no." I sometimes think that at this point we were probably deceived in thinking we could abort pneumonia or relieve la grippe by the liberal administration of the malarial specific; whereas we were only facing our common old foe—malaria, with its complications.

*CEREBRO-SPINAL MENINGITIS.

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GULFPORT.

My object in writing this paper is to present to the members of this society, for discussion, the chief characteristics of a disease that has during the past year attracted considerable attention in Mississippi, Texas, Louisiana and other Southern States.

It matters not what has been its history, or frequency of occurrence in the cities of the North or in other countries; the fact remains that epidemic spinal meningitis has, until recently, been a rare disease in the South. For this reason, few, if any of us, are as familiar with the symptomatology and treatment of the disease as we should be at the present time. In fact there exists amongst general practitioners the greatest diversity of opinions and inadequate knowledge of the disease.

Osler defines cerebro-spinal meningitis, or spotted fever, as an infectious disease, occuring in epidemics and sporadically, caused by the diplococcus intracellularis (Weichselbaum). Tyson says that while the disease may be regarded as contagious, it is not highly so, being in this regard very much like tuberculosis, pneumonia and other infectious diseases. As a matter of fact, it appears in certain localities under certain conditions, very much as an epidemic of la grippe or pneumonia. All of my authorities agree that it is not directly contagious, nor is it transmitted through the clothing or excreta any more than is tuberculosis, typhoid fever or any other similar disease. The epidemics in large cities have spread very irregularly, breaking out in different localities, without any reference to the first cases, and rarely more than one or two in the same family develop the disease. This is entirely in accord-

*Read before the Harrison County Medical Society.

ance with our experience in Gulfport. It is now over six weeks since the death of J. A. Spiers and not one of his family, neighbors or nurses have shown any symptoms of the disease, and I have now permitted his children to return to school.

The diplococcus intracellularis meningitidis was discovered by Weichselbaum in 1887. It is found within the polynuclear leukocytes in the cerebro-spinal fluid, the blood, the mucus exudate of the nose and throat. It takes the usual stains, but is negative to Gram's method. It grows in Loeffler's blood serum with some difficulty, forming round, whitish, shining colonies, and is easily differentiated by bacteriological methods from the pneumococcus and gonococcus, as well as from the diplococcus lanceolatus of Frankel.

The period of incubation of the meningococcus is still undetermined. The colonies develop in Loeffler's blood serum within twenty-four hours. It is most likely that after the invasion of the system by the diplococcus, symptoms will manifest themselves within a period of from one to three weeks. This is in accordance with the rule of other infectious diseases. It is probable, however, that the bacteria may be harbored in the mucous membranes of the nose and throat for months, and even years, and so we have the meningitis carriers, just as we have the typhoid carriers. This may explain to some extent the reason that the disease is prone to linger in certain localities, and is even endemic in some of our large cities.

Various predisposing causes are given, such as cold, exposure, dampness, over-work, fatigue, general debility, in fact anything that diminishes the power of resistance or the opsonic index. The disease appears most commonly in the winter and early spring under about the same conditions that develop pneumonia and la grippe, and generally disappears in the summer.

Like most other diseases, cerebro-spinal meningitis rarely ever manifests all of the symptoms in a given case. There are, however, a group of prominent symptoms that generally serve to characterize it. Among these are sudden onset, chill, low fever, ranging about 102 or 103° F., projectile vomiting, intense headache and pain in the back, rigidity of back and neck, hyperesthesia, characteristic eruptions, photophobia, convulsions, strabismus, paralytic symptoms, arthritis, albuminuria, leukocytosis and Kernig's sign. Delirium and coma mark the end in fatal cases. The most constant symptoms are the intense pains in the head and back, and rigidity of the mus-

cles found in nearly all cases; eruptions are found in fifty per cent. or probably two-thirds of the cases. Kernig's sign is present in ninety per cent. of cases. Opisthotonos is a valuable sign, though not so constant as Kernig's sign. In a mild epidemic, it may be impossible to make a diagnosis without finding the diplococcus.

It has been my fortune, or rather misfortune, to attend the only undisputed case of cerebro-spinal meningitis that has ever died in Gulfport. As the case may offer some points of interest, I thought it proper to submit a brief history of it for your consideration.

On the 29th. day of February I was called to the patient's house. He was taken that morning with a severe chill and intense pains in the head and back of the neck; had vomited some and complained of a peculiar stiffness all over his body. Previous history was negative, except that the patient had been exposed a good deal on the front end of the car, where he worked as motorman. He had been to me several times for medicine for a cold which he said he was unable to get rid of. Examination showed a slight fever 101 or 102° F.; pulse normal, respiration normal. As I had treated him for malaria once or twice before, I prescribed some purgative and quinine and left. That night I was called up, in the early morning, but was out and could not attend. Shortly after daylight, I called, and found the patient resting under an opiate which had been given hypodermically by another physician. The family were very much excited and stated that through the night he had become raving mad,was tearing up the bed clothing and fighting every one in the room. Fortunately morphine had a very happy effect. I left some sedative and stimulants, and promised to return that evening. That evening I called again, found the patient somewhat rallied, but still suffering with intense pain in the head and back. The back of his neck was rigid, and very tender, but no opisthotonos. An arthritis with an extravasation around the elbow was present, which his wife attributed to his fighting. His temperature was still about 103° F., pulse slightly above normal and no change in respiration. It occurred to me at once that the symptoms were out of all proportion to the temperature and I gave up the idea of malaria. My next tentative diagnosis was rheumatic fever. I gave some directions as to administration of sedatives, prescribed a preparation of salicylic acid and left. That night I was again called up to administer a hypodermic and it had the same happy effect.

Delirium continued to increase all the next day and from that time he never spoke again, except to groan and exclaim: "My God, My God." Symptoms of paralysis now began to show up, and a slight convergent strabismus which his wife attributed to his trying to read with fever on. By the next morning his symptoms had become so alarming that I thought it my duty to notify the family that he was in a very critical condition. I at once engaged a trained nurse and Dr. Le Baron was called in consultation. It is needless to say that I had already suspected cerebro-spinal meningitis. The absence, however, of the characteristic eruption, opisthotonos and Kernig's sign still left me in the dark. An examination of the blood showed malaria absent, but slight leukocytosis. Examination of the urine showed presence of albumin and some blood. The blood pressure register was about 160 to 170. In view of the urinary findings and blood pressure, we now began to suspect acute uremic poison. His temperature continued to range from 102 to 103° F., until shortly before death, when it rose suddenly to 104° F. On the 3rd. his delirium deepened into coma, and he developed symptoms of broncho-pneumonia; and on the 4th. I was informed by telephone that he had died early that morning. His death was so sudden and the symptoms so mysterious that I felt it my duty to exhaust every means in my power to arrive at a correct diagnosis. I therefore went back with the undertaker and made a spinal puncture between the 4th. and 5th. lumbar vertebræ, and obtained about a drachm of cerebro-spinal fluid.

I noticed that the fluid was turbid and contained considerable amount of fibrinous exudate, which in itself speaks for meningitis, as the normal fluid of the spinal canal is clear, but I awaited the microscopical findings.

Part of the fluid I sent to the State Bacteriologist at Jackson, and part I turned over to Dr. Caraway of Gulfport, with instructions to examine for diplococcus intracellularis (Weichselbaum.) The first examination in both cases proved negative. That night, however, I received the following telegram from Jackson: "Diplococcus present in examination today, Harold B. Wood, State Bacteriologist." A letter followed in which Dr. Wood stated that the case was undoubtedly one of cerebro-spinal meningitis. In the mean time, Dr. Caraway had also succeeded in isolating the diplococcus. With these proofs in my hands, I felt that there was no longer any doubt

as to the diagnosis. I immediately called a meeting of the City Board of Health and laid the matter before them.

We immediately began to take steps to prevent the spread of the disease. The house was thoroughly disinfected, and fumigated and the bed-clothing was burned. The children were kept away from school for about three weeks. About this time two or three other suspicious cases were reported to me by other physicians, and I treated them all in the same way. It has now been over a month and there has been no further spread of the disease. If no further cases develop in the near future, I shall feel safe to say that our two or three cases here were sporadic and not epidemic.

Cerbro-spinal meningitis is classified by Tyson as a grave disease. The mortality was from thirty to seventy per cent. previous to the introduction of Flexner's Antimeningitis serum. Since the introduction of the serum, however, the mortality has been somewhat modified.

The serum was the result of experiments carried on by the Rockefeller Institute during the epidemic in New York in the years 1905 and 1906. It is, therefore, only about five or six years since its introduction, and it can hardly be said yet that it is beyond the experimental stage. Flexner gives the mortality under treatment with his serum as twenty-five or thirty per cent. Other experiments in this country have confirmed Flexner's. Quantities of serum were sent by the Rockefeller Institute to various countries in Europe where epidemics prevailed. The results in Germany were not very encouraging. Those in England, Scotland and Ireland all coincided with Flexner's. The best results, however, were shown in France, where the mortality was reduced to about twelve or fifteen per cent. The experiments at Dallas, Texas, during the last two or three months show a mortality of twenty-five per cent. This includes, however, many cases who were brought into the hospital in a very bad condition. The results of these experiments are being tabulated now and will soon be published by the "Research Laboratory of the Department of Health of New York City," which had a representative on the field.

The serum is obtained by immunizing horses, first with dead and then with living cultures of diplococci, which are injected first subcutaneously and then into the veins. The present method of standardization of the antimeningitis serum is by determining its opsonic index, and we have no definite measure of efficiency, as we have in the units of antidiphtheritic serum.

The dose, therefore, is given in the number of cc. and not units. From twenty to forty-five cc. are generally required. It was found that subcutaneous and intravenous injections were too slow and uncertain, and the serum is injected directly into the spinal canal.

Originally the amount of serum injected corresponded to the amount of fluid removed. During the epidemic in Dallas, Texas, however, it was found that the blood pressure furnished a more convenient guage to determine the amount of serum that could be used with safety. The operation may be repeated every twelve or twenty-four hours. In making your spinal puncture, look out for sudden fall in blood pressure, deepening coma, stertorous breathing, dilated pupils, incontinence of urine and feces. These are signs of danger.

While Flexner's serum has not yet achieved the brilliant results of diphtheria antitoxin, it has nevertheless considerably diminished the rate of mortality and it is to be expected that further improvements will still increase its usefulness to suffering humanity. In the mean time, it is but just to say that no other treatment offers even the slightest hopes.

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*PELLAGRA.

D. J. RUSH M.D.,

PHILADELPHIA.

It is with no little degree of hesitancy that I attempt to write a paper on this much discussed subject—pellagra; a subject that we as yet so little understand; but it is with constant and diligent endeavor of the student that all great problems are solved. Hence I will try to give you a few thoughts on this subject.

I will not however attempt to enter deep into its history or etiology but confine myself to my personal observations and experience.

Pellagra is not a new disease as it has been known in Europe and some other foreign countries for nearly two hundred years, but here in the United States it is comparatively a new disease. When I was a student, some twenty-five or twenty-six years ago, I never heard of pellagra. I never saw a case

*Read before the Newton-Neshoba-Winston County Medical Society.

of it until about five years ago and then I did not know what it was.

Since that time I have seen quite a number of cases, many of whom I have treated, with varied results.

As I have already stated, I approach this subject with much hesitancy as we have so many adverse opinions as to the etiology, pathology and treatment; but my paper would not be complete if I did not give my opinion.

Etiology may be divided into dietetic, climatic and season temperature and individual predisposition.

I am willing to accept the idea that maize or Indian corn and its products taken as a food have much to do with causing pellagra but I will go further—that not only Indian corn and its products, but sugar and starchy foodstuffs that are convertable into sugar in the process of digestion and assimilation are also large etiological factors. Nor do I believe that these alone are sufficient to cause pellagra, but climatic and season temperature play a most important part in developing this disease.

We don't have the trouble developing in colder climates and most all cases improve when removed to a cold climate. We don't have the trouble developing in the cold season of the year and we do find most cases improve or symptoms abate in the winter months, thus proving beyond a reasonable doubt that climatic and season temperature are factors in the etiology.

Then we have the individual predispostion as a factor in the cause. What constitutes this individual predisposition we do not know, but we do know that pellagra does develop often in some member of the family when other members of the same family existing under the same conditions and environment remain entirely free from it.

Now to go back to the dietetic cause, I believe it is pretty generally accepted that diseased or damaged Indian corn and its products used as food tends to develop this disease, and if this theory be true, and I am inclined to believe it is, then this explains why we have had such an outbreak of this disease in the South in the last five or six years.

Cotton having risen to such a fancy price in the market, farmers in order to raise larger crops of cotton planted their fields largely in that product, thereby neglecting to plant and raise sufficient foodstuff, and were necessarily forced to buy foodstuff such as corn and corn meal shipped from the West in car lots, packed in damp box-cars where it became more or less damaged.

I have stated before that I believe sugar and starchy foods, that are convertable into sugar in the process of digestion, act as factors in developing pellagra.

I find from statistics that in the United States and other countries where pellagra has developed and increased, there has been an enormous increase in consumption of sugar and starchy foodstuff, inhabitants making them their principal articles of diet.

Pellagra develops only in warm climate. We see it develops only in warm seasons—summer months; and we know that the metabolic activity is weaker in warm climates and weaker in warm seasons than in the colder ones and we also find, when the process of metabolism is interfered with, arrested or weakened, that chemical changes take place in the assimilation of sugar or carbohydrates, developing toxines which entering into the circulation produce an auto-intoxication resulting in the symptom-complex—pellagra.

The sun's rays, when the skin is exposed to it, seem to be the exciting cause in the production of the erythema or dermatitis of pellagra.

The symptoms of pellagra are many and varied, the commoner being: derangement of the nervous system with mental depression and insanity; derangement of the digestive system with diarrhœa and constipation, emaciation and general debility; stomatitis and the characteristic dermatitis.

It usually commences with a stomatitis in the summer months which is very stubborn to treat but tends to get well in the winter, to break out again with the approach of warm weather.

There is more or less languid or depressed feeling and mental inactivity, which as the disease progresses may develop into actual insanity. Headache and sleeplessness are common.

Indigestion is almost a constant symptom—patients often complaining of a burning pain or soreness in stomach and bowels—also of gaseous collections in the stomach. Appetite is variable but usually poor and the bowels are either constipated or loose. As the disease progresses we have emaciation and general debility.

The dermatitis is very characteristic but is not always a constant symptom. It usually appears on the parts directly exposed to the sun's rays: the hands and forearms, face, neck, feet and legs. We find it varies in degrees of severity from a

mild dermatitis or erythema resembling a sun-burn to a severe suppuration and sloughing of the skin. The affected skin is of dirty brownish color and has a rough, dead feel. The epidermis may after a time peel off, leaving a pale slick surface of new skin.

The urine is usually of low specific gravity. Albumen is present in most cases.

All of these symptoms usually subside or entirely disappear at the approach of cold weather, to return again in the spring or summer months.

Diagnosis of pellagra is easy when you have a well-developed case, but in mild cases, when we have only a few symptoms and they are not well marked, it is difficult and often impossible to make a positive diagnosis. Very probably many cases owing to the mildness or symptoms go unrecognized or are treated as something else.

In the more severe type the prognosis is always grave, but of the milder form under proper treatment a large percentage recovers. I believe that owing to the mildness of symptoms probably many cases go unrecognized and get well without any treatment.

Treatment is both prophylactic and remedial. Prophylaxis is the most important and consists of total abstinence from any Indian corn products and sugar, also such articles of diet as are convertable into sugar. This is only practical in individual cases.

Remedial treatment may be divided into dietetic, medicinal and climatic.

A pellagrin should not be allowed diet that contains the products of Indian corn or sugar, but such articles of diet as milk, eggs, vegetables and fruits that do not contain sugar and starch, meats, fish, oysters, broths, etc., to suit the individual taste are admissable.

As for medicine we have no known drug that is a specific or is at all a reliable remedy. Arsenic, iron, quinine and strychnine have all been largely used with only partial results. Of these arsenic in its various forms seem to have more influence over the disease than any other. I have used it in all my cases except for the last two or three and think that atoxyl and the cacodylate of sodium have given the best results.

I give atoxyl in from three to five minim doses hypodermically once daily for a week or ten days, then every alternate day. Sodium cacodylate is put up in ampules, one dose to the

ampule, and is given the same way as atoxyl. I have used Fowler's solution and other preparations of arsenic with not quite as good results. As for salvarsan, I have no personal experience. I think it a dangerous drug that should be used with extreme care, however, if I were to use salvarsan I think I would prefer the newer preparation, neo-salvarsan. It is claimed by Prof. Ehrlich that it is safer and not near so painful.

I have given quinine and have found it in some cases to act very well in large doses, thirty grains per day, while in other cases I could see no good results. In a few cases I have tried urotropin with no apparent results.

After all, the medical treatment is largely symptomatic. Tonics for the debility, digestives for the indigestion, and so on.

Upon this last conclusion I have this year confined my treatment to dieting my patients and giving nitric acid, fifteen to thirty drops of the dilute form, in a glass of water before each meal and find that the three cases I have treated this way this summer are going remarkably well.

As for the dermatitis I use the oxide of zinc ointment and have the patient to wear gloves with long gauntlets up to the elbows in order to protect the skin from the sun's rays.

As to climate, I believe that a colder climate where the disease is never known to develop is beneficial. I think we should try to get our patients off to some place in some of the Northern States during the hot summer months. I have one patient whom I sent away last summer and who is still in a high altitude in New Mexico and doing well.

In conclusion, I wish to say that this is a most dreadful disease, that its prevalency here in the South is simply appalling. In one county in this state, Lauderdale, the health officer in one report gives forty-nine cases. Reports from other sections all over the South show that this disease is on the increase and is rapidly spreading. If this constant increase and spread is not checked what is to be the result? I shudder as I contemplate the answer: The people of the whole country are looking to the medical profession for relief, for protection. Are we going to be able to give it? Now it is up to us as physicians to meet the exigencies of the situation, to study out the cause of this dreaded malady, to meet its prevalency with an effective treatment, both prophylactic and remedial, that will wipe it from the face of our fair Southland.

Letter to The Editor.

Jackson, Miss., August, 1912.

Dear Sir:

I am making an effort to locate every deaf child in Mississippi. You can be of great service along that line and at the same time be instrumental perhaps in bringing the blessings of education to some such child.

Will you please ask your readers to send me the name and postoffice address of parents or guardians of any such children they may know of?

The State has provided for their education and training so as to make them independent, self-sustaining citizens. None are so poor that their children cannot be admitted.

In helping me in this canvass you may be helping many that need education.

Thanking you in advance and hoping through your valuable paper I may extend the benefits of this great Institution, I am,

Yours truly,

J. R. Dobyns, Superintendent.

Notices.

President Glass has appointed Dr. E. H. Galloway of Jackson chairman of the section on surgery in place of Dr. J. G. Gaither of Oxford who has moved to Kentucky.

The American Electro-therapeutic Association will hold its next annual meeting at the Jefferson Hotel, Richmond, Va., Sept. 3, 4 and 5, 1912.

This is the largest body in the world whose object is devoted exclusively to physical therapeutics, i. e., electricity in all its forms, hydrotherapy, phototherapy, mechano-therapy, exercise therapy, dieto-therapy and other natural agencies.

The membership comprises the leading experts in this country, who are engaged in this special line of work with fraternal delegates from Canada, England and France.

Dr. J. C. Walton of Richmond is chairman of the committee of arrangements.

MISSISSIPPI MEDICAL MONTHLY.

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OFFICIAL ORGAN OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION AND ITS COMPONENT SOCIETIES.

SUBSCRIPTION ONE DOLLAR PER ANNUM.

Of all weaknesses manifested by the physician, manifested in such form that their patients cannot but recognize it, is the common complete inability to write a prescription that will emerge from the hands of the pharmacist in a pleasant looking, palatable form. The conditions in our medical schools and our grammar schools are in this respect quite similar. In each the curriculum is quite overloaded with frills and new ideas while the three common Rs on which all education is based, whether medical or otherwise, are quite forgotten.

No one feels more keenly than the recent graduate, his utter unpreparedness in practical prescription work and, right here, it opens a wide field for the medical college of today. A man may be able to trace generations of protozoa, spermatozoa and other animals to their beginning, and be unable to tell whether bismuth subnitrate makes a clear solution or not. He is likely to censure the druggist for a thick, white sediment in the bottom of the bottle.

So, blindly groping, at last comes with experience, knowledge, but how useless this waste of time! A steady drill, on blackboard and by criticism, would soon instil into the minds of the students the salient principles of prescription writing, and save the physician many a bad hour worrying over the mess he has written for.

A workman should be thoroughly acquainted with his tools and the manner of using them. In the form of the prescription we apply our tools and if the form be bad, the result be unpalatable, we stand judged and condemned by our work; a con-

demnation justly merited but one easily avoided by the application of the simple rules of prescription writing.

S. Myers.

In response to a number of questions, we took up the matter of the author of the star examination paper published in our last issue. Dr. Smithson is inclined to believe that he is not a gradnate. Owing to some misunderstanding, a few of the men who took the examination did not produce their diplomas as evidence of graduation. These Dr. Bryan, personally, required to make oath to the effect that they were graduates, with the understanding that they might then take the examination but that in the event that they passed their licenses would be held up until their diplomas were filed with the secretary of the Board. The man in question was one of them. Considering the standard that our Board has always set, it is not necessary for us to say that he did not pass. If our memory is correct the paper received a mark of eight and a half points, and would not have been rated so high but for the fact that Catchings of Woodville begged the other members to "be liberal with the poor devil."

Obituary.

The following resolutions were adopted by the Leflore County Medical Society in regular session August 6th. 1912:

Whereas, our brother, Dr. David Smith Humphreys has been taken from us by untimely death while still in prime of his life and in the fullness of his powers, and whereas we feel most keenly his loss as an associate from whom we always got inspiration, as a friend in whom we could trust, and as a brother physician on whom we could rely; therefore be it

Resolved, That the medical profession has lost one of its most capable members, one whose great ability was devoted to the advancement of the art of healing, and one whose efforts were most untiring when giving relief to the suffering.

Resolved, That his patients have lost an advisor and counsellor who gave his life to their interest; he was at the command of them all; the rich and the poor alike received his kindly ministrations. Most loved by those who knew him best.

Resolved, That the community has lost one of its foremost citizens; one who could find time from exacting professional duties to further the interests of his town and county; one who could advise well and shirked no civic duty.

Resolved, That the members of this society, one and all, extend to the heart-broken wife and children their deepest sympathy in this their great affliction, and assure them of a continuing interest in their welfare.

Resolved, That a copy of these resolutions be sent to the bereaved family; that a copy be sent to the county papers for publication; and that they be spread upon the minutes of this society.

E. W. Hunter,

samples of urine, blood or sputum to some distant laboratory. The authors are frank and hit from the shoulder, advising the man who does not do a good deal of such work to let the more complicated examinations alone—send them to the laboratory. But in the simpler examinations they rightly contend that every man should be his own microscopist and proceed to show him the best easy and cheap way to do it. The book is a gem. Every "seven-days-in-the-week" doctor, who does general practice, ought to have one.

E. F. HOWARD.

THE CARE OF THE SKIN AND HAIR by W. A. Pusey A. M.,M.D., Professor of Dermatology in the University of Illinois. D. Appleton & Co., New York.

This is a capital little handbook, that will serve the purpose of quick reference and gives a number of hints that will enable the doctor to answer many of the questions that are put him regarding the care of the hair and skin and the errors of life upon which their abnormalities are generally dependent

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*PUERPERAL INJURIES.

J. W. GRAY M.D.,

CLARKSDALE.

I am led to offer this paper by the fact that too often, through carelessness in not making the necessary examinations, we allow women who are injured during childbirth to suffer needless pain and danger.

Laceration of the cervix and of the perineum will occur in the hands of the most careful and competent obstetricians, and I have no patience with the man who boasts that he "never had a tear in twenty years' practice." If he believes that statement when he makes it, it is either because he never looks for one or else doesn't know one when he sees it.

There is absolutely no way to prevent laceration in every case. "Supporting the perineum" is a snare and a delusion. The only means I have found of any value is slowing down the pains with chloroform and at the same time pressing the head firmly upward against the symphysis.

But in spite of any and all efforts, tears will occur and should invariably be looked for, and, if not of the very slightest degree, should be immediately repaired, for the reason that even minor tears are sometimes extremely painful, and also form a port of entry for infection. In more extensive lacerations, immediate repair is urgently recommended.

Laceration of the perineum is divided into three groups: first, second and third degree. The first degree is when the fourchette and skin of perineum, only, is torn. The second degree extends through the vaginal mucous membrane, a portion of the perineal body and exposes the phincter ani muscle. It does not usually follow the median line, but extends obliquely downward and outward. Usually the sulcus on the same side is ripped, but frequently both sides, forming a tongue of vaginal mucosa. The third degree tear extends completely

*Read before the Clarksdale and Six Counties Medical Society.

through the perineal body and sphincter ani muscle and up the rectum. Very infrequently the head is forced through the central portion of the perineum and appears entirely surrounded by skin. More frequently, but not very often, there may be only very slight visible lesions, but a submucous separation of the levator ani muscle occurs, which if not noticed, and repaired at once, will later give much trouble by relaxation of the vaginal outlet.

The obstetrician will save and cause much less pain if the operation is done at once, while waiting for the placenta to be delivered. The sensibility of the parts is obtunded and an anæsthetic is not often needed. Another advantage is that the temptation of trying to remove the placenta, before it has completely separated, is removed.

Most authors recommend silk-worm gut as the best material, but personally I have found twenty-day chromicized cat gut to be entirely satisfactory, both for deep and superficial sutures.

The patient should be drawn to the edge of the bed in the lithotomy position, the legs being held by assistants, and a pad of sterile cotton, or gauze, introduced high up into the vagina with dressing forceps in order to keep the blood from the field of operation.

In complete tears the rectum should first be repaired with cat gut or fine silk sutures, which should be knotted into the rectum and not cut short, but the ends allowed to protrude through the anus. After the gut is repaired, the torn end of the sphincter should be isolated and firmly sutured with heavy catgut.

Should there be any vaginal tears, these should be next repaired with cat-gut, from above downward to the skin margin. And just here I wish to lay special stress on the necessity of carefully and neatly closing the vaginal tears, as a failure to do this properly is nearly always the cause of the failure to get good union of lacerations in the perineum. The sutures should be introduced some distance away from the edges of the wound (as the great swelling frequently puts considerable strain on the stitches and causes them to tear out) in an oblique direction, going well down to the base of the wound, and then brought out obliquely on the opposite side. The reason for introducing the sutures obliquely is that, when tied (not too tightly), they exercise a lifting effect, and prevent bagging just at the vaginal outlet and retention of the lochia. This applies

particularly to the last two or three sutures, which I prefer should include the vaginal part of the perineal body.

After carefully closing the vaginal tears, the perineal body may then be sutured with heavy cat-gut, placing superficial sutures of lighter material where necessary to obtain perfect apposition.

The after-treatment is simple, it only being necessary to keep the parts scrupulously clean. It is not usually advisable to keep the patient's legs tied together, unless she be very unruly. Neither is it necessary to use the catheter. The bowels should be confined for two or three days where the tear has been complete, but not otherwise.

Slight laceration of the cervix may be considered normal in most primiparæ. Such usually heal rapidly and may be disregarded.

In other cases the tears may extend deeper, on one or both sides upward to the vaginal junction, or even across the fornix into the lower uterine segment, accompanied by profuse hemorrhage.

In some cases the anterior lip is caught between the head and symphysis and so compressed that it is torn off. Occasionally in an elderly primipara the entire vaginal portion may be torn off, when the pains are strong and the os rigid.

A diagnosis of laceration of the cervix cannot be made except by digital examination or direct inspection. Should there be free hemorrhage after the completion of the third stage of labor, and the uterus can be felt firmly contracted, then a tear may be suspected and a further examination can properly be made. In the absence of hemorrhage, I deprecate strongly any examination or manipulation, since it exposes the woman to unjustifiable risks of infection. However, an examination should be made about six weeks after delivery, especially if there be the slightest evidence of a tear. Most cervical tears, in the absence of inflection, heal kindly, and those which do not, and produce symptoms, can be better dealt with at a later period when there is no danger of infection.

When the diagnosis is made, the tears can be easily repaired by pulling down the cervix with bullet forceps and suturing with strong cat-gut, always beginning at the upper angle of the wound and tying the sutures down. Those tears involving any considerable portion of the uterus can be dealt with properly only by opening the belly.

*A FEW REMARKS ON TETANUS AND REPORT OF A CASE.

C. B. McCOWN M.D.,

PRAIRIE.

Tetanus is an acute or subacute disease, producing violent tonic spasms with clonic exacerbations, caused by a drum-stick bacillus that multiplies by spores. The period of incubation is one to three weeks; the shorter the period of incubation the more serious the prognosis. There may be prodromal symptoms for a few days, but the earliest pathognomonic symptoms are, the muscles of the face are drawn producing a distressed expression, deglutition is difficult and speech is interfered with. The wounded limb is in early tonic contraction. Kernig's sign of tetanus (flexion contracture of knee-joint) is an early sign. These symptoms are soon followed by trismus or locking of the jaws, tonic contraction of the muscles of the back and abdomen. The least touch or loud noise will bring on a spasmodic contraction.

Treatment consists in keeping absolute quiet in room, and nourishing the patient. Next control convulsions, which I have succeeded best in doing with chloral and bromide of potassium; when I could not give this by mouth or rectum I used physostigmine hyodermatically. Whatever used is necessarily given in very large doses.

The wound, if one can be found, should be thoroughly opened, canterized and dressed with moist bichloride dressing, and washed daily with hydrogen peroxide.

John Norman Henry reports four cases treated in the Pennsylvania Hospital by intra-spinal injections of one to two drams of a 25 per cent. sterile magnesium sulphate solution, with one recovery and three deaths. After each injection, convulsions would cease completely from two to four days. The injections must be used in decreasing doses.

My recent experience has given me confidence in tetanus antitoxin. I would not feel that I had done my duty if I failed to use it at the very earliest possible moment. It should be used in large doses, fifteen hundred to three thousand units every eight to twelve hours.

Amalgia and Mendes have found when tetanus toxin is kept in contact with cholesterine two or three hours, that animals could be injected with several times the fatal dose of the toxin,

*Read before the East Mississippi Four County Medical Society.

without killing the animal. Animals having tetanus were benefitted by cholesterine injections. They report good results from its use in human beings; they use from one to one and one-half grams daily.

Case record. V. R., white girl, aged four, on May 14th. suddenly gave a loud scream and fell to the floor. As the child was eating bread it was thought she was choked. I saw her half an hour later. She was resting perfectly quiet. I could find nothing abnormal about her, but a peculiar distressed expression of the face. I left her four grains of calomel and santonine. Six hours later I was notified that she had had a hard spasm, come at once. I found her this time resting quietly but unable to straighten out the left leg, could hardly speak or swallow, could not sit up and could hardly open her mouth. Upon inquiry I found she had stuck a splinter into her left foot about ten days before. The place on the foot was almost healed but after removing the scab I found a little pus. The wound was thoroughly opened and cauterized and a moist dressing applied. Convulsions gradually became more frequent and harder. She was given that night twenty grains each of chloral and potassium bromide and tetanus antitoxin was ordered. I first gave chloral and potassium bromide in seven grain doses but got very little effect until twenty grain doses were given.

15th. Pulse 115, temperature 99½° F. Each dose of chloral and potassium bromide controlled convulsions for about six hours.

16th. Pulse 130, temperature 101° F. Rested well until night, was unable to swallow anything, was given fifty grains chloral and one dram potassium bromide by enema which gave relief for eight or ten hours.

17th. Pulse 132, temperature 101½° F. Still unable to swallow. Repeated enema of chloral and bromide potassium and gave fifteen hundred units antitoxin at eleven a. m. and four and ten p. m.

18th. Pulse 124, temperature 100½° F. Gave fifteen hundred units antitoxin. Bowels would not retain chloral; gave one-hundredths grain physostigmine every two hours. 4 p. m. Convulsions very frequent, pulse 130, temperature 102⅘° F., physostigmine increased to one sixty-fourth grain every two hours.

19th. Pulse 130, temperature 102° F. Can swallow nourishment well. 10 p. m., convulsions very frequent and hard, can swallow nothing, pulse 170, temperature 104⅕° F.

20th. Condition still bad. Pulse 160, temperature 103° F. Fifteen hundred units antitoxin given. Rested fairly well rest of day. 9 p. m., pulse 140, temperature 102⅕°.

21st. 10 a. m. Pulse 130, temperature 101½ F°. Convulsions much lighter, gave chloral by mouth and fifteen hundred units antitoxin given.

22nd. Pulse 116, temperature 100° F., jaws relaxed for first time. Improvement rapid to complete recovery.

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*THE PREVENTION AND TREATMENT OF MALARIA IN THE NEGRO RACE UNDER DELTA CONDITIONS.

WILLIAM B. HARRISON M.D.,

WHITNEY.

The object of this paper is not to go into a general dissertation upon the subject of malaria, but to briefly call attention to a few practical points regarding the prevention and treatment of this disease in the negro, as we find him on our Delta plantations.

The negro race is so proverbially improvident and fatalistic in thought that any effort toward prophylaxis would appear well nigh hopeless. Anything in the way of extensive screening is impractical. Those of us who have had experience with negro servants know to what extent screen doors would remain closed and screen windows remain intact were the negroes left to themselves with these things.

Fortunately the mosquito not only disseminates malaria, but has a sting to its bite as well, which is quite disagreeable. For this reason, it is possible to get the negroes to follow one or two simple proceedings which materially lessen the number of malarial infections. Chief among these is the use of the mosquito bar. By this means the tenants are protected during a time which is most important, while they are asleep and vigilance is relaxed. Another method of keeping off mosquitoes which is in common vogue is the building of smudge fires on the windward side of the cabin, also the production of smoke within the house.

Another important step, one which the planter himself must take, is the finding of a suitable location for the cabin. It is a common practice to build along the banks of bayous

*Read before the Clarksdale and Six Counties Medical Society.

and lakes on account of the fact that here is usually found high, sandy, well-drained land.

Of course it is desirable to build on such soil and it is all very well to locate the house on a stream or lake provided the water is deep, clear of vegetation and well stocked with fish, but too often we find houses located contiguous to a bayou or brake which dries to holes in the summer months, these being choked with growths which offer the best possible breeding places for the anopheline larvæ.

The character of drinking water has but an indirect effect in the production of the disease.

The treatment differs from routine treatment in the whites, not so much in kind as in method of administration. Negroes are so prone to neglect the taking of medicine, the nearer we can come to the giving of all under the physician's eye, the better.

The dose of calomel employed is larger than that ordinarily recommended in the text-books. I have never been able to get more than watery actions from the bowels with the smaller doses. Ordinarily, I give from fifteen to forty grains in conjunction with the compound extract of colocynth. This thoroughly cleanses the bowels, removes accumulated bile from the system, and acts as a diuretic. Salivation is rare. If the negro can be seen directly following the chill, it is better to give a massive dose of quinine and follow this with the same drug on succeeding days. In æstivo-autumnal malaria it is better to give the quinine in small doses frequently repeated.

The follow-up treatment is most important, and at the same time most difficult to accomplish. Dr. W. M. James, of the Canal Zone, in a recent article calls attention to the results of researches regarding a comparison of the duration of fever with the length of time parasites were found in the blood, the patients being under routine treatment, which consisted of twenty grains of quinine on admission and ten grains three times a day following. The method of examination was the Ross "Thick Film."

Of the tertian cases, the average length of time which fever continued was 1.72 days, while the parasites were found on an average of 3.27 days. Of the æstivo-autumnal cases the average duration of fever was 2.12 days, and the average length of time parasites were found 3.43 days.

In the light of these figures, it is easy to see why we have so many relapses. Indeed, were it not for the natural relative

immunity of the negro, and the tendency to spontaneous cure, this disease would produce sad havoc in this people. As it is, pernicious malaria is not common, neither is the chronic type, while malarial cachexia is rare.

Owing to a prejudice against capsules, and a hysterical difficulty in swallowing them, it is often less difficult to get these patients to take a disagreeable potion than to take quinine in what is, to the Caucasian, the much more pleasant way. These patients will often take the drug in coffee.

For the chronic cases, the well known mixture of Gadberry is excellent, but if there is doubt as to the patient's taking it, some of the less disagreeable preparations had better be usd. This mixture has the great advantage of being non-toxic.

Hemoglobinuric fever is so rare that a discussion of this condition would be out of place.

In conclusion, I feel that an apology is due this body for imposing upon it a subject so hackneyed and subject matter so trite, but when we take into consideration in the fact that in parts of the delta the negro race is preponderant in the ratio of forty or more to one, and that a conservative estimate would place the ratio of malarial patients to non-malarial at least three to one, the importance of the repetition of these discussions is well seen.

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*THE SURGICAL TREATMENT OF HEMORRHOIDS.

J. O. GURNEY M.D.,

TUPELO.

There is constant need for physicians to be reminded of those every-day, common-place conditions, of which, from seeing often, they become more or less careless.

That of hemorrhoids seems to me to be in the category of ills we are prone to look upon as very small afflictions, and often prescribe for without even giving an examination, only taking the word of the patient for the condition that he thinks exists.

A hemorrhoid, or pile as it is commonly called, is a dilatation of a vessel or vessels supplying the lower two inches of the rectum, which may rupture and become thickened or indurated from the multiplication of cellular tissue. The anatomy of the lower part of the canal, with its loose tissue and vessels run-

*Read before the East Mssissippi Four County Medical Society.

ning longitudinally, connected by small transverse vessels, is subject to great variations in pressure during defecation, especially in constipation; this predisposing to rupture of small vessels and increase of cellular tissue.

There are two divisions of hemorrhoids: external, those at the margin of the anus, and internal, or those within the external sphincter.

Indications for surgical treatment of hemorrhoids or piles are several: enlargement with persistent hemorrhage, prolapse of rectal mucosa, prolapse and thrombosis and to relieve continual suffering when riding, sitting or walking.

Contra-indications for operation are: diabetes, tuberculosis, severe anemia and albuminuria. Though the operation is not looked upon as very serious one, there should be no neglect in looking into the constitutional condition of the patient.

The bowels should be well opened with oil or salts on the day previous to the operation and an enema given several hours before the operation, so that the bowel will be in the best possible condition for operation.

The anal region should be well cleansed, with soap and antiseptic solution. Place patient in lithotomy position, dilate rectum with bi-valve or multi-valve speculum, or by introducing thumbs and making continuous pressure laterally.

Methods of operation are several: ligature and excision, clamp and cautery, clamp and suture, and Whitehead's operation.

The first mentioned is simplest and best adapted to the majority of hemorrhoids, because you can more readily reach the piles which are higher up; and there is less danger of hemorrhage following this procedure than the other operations.

Ligature and excision. After cleansing and thorough dilatation of rectum, each pile is seized with volsellum and the mucus and sub-mucus tissue dissected from below with blunt scissors, so as to have the remaining stump as small as possible to include the vessel supplying it, according to Allingham. Then place ligature of sterilized silk around the stump, securely tying it. Do each pile likewise, taking care to divide the tissue longitidinally and see that hemorrhage is reduced to a minimum, also that there is left between each pile sufficient tissue to avoid too much contraction.

The object for division of tissue from below is two-fold, first it reduces the size of stump and a better hold can be had, reducing the danger of ligature slipping and hemorrhage re-

sulting. The operation being finished, a suppository of morphia is introduced, iodoform gauze applied, and "T" bandage.

Bowels are controlled by opiates and astringents for four or five days, food reduced to minimum, bowels opened on the fifth day with oil; after which a gradually increased daily diet until full diet is reached, the usual length of time required for recovery being nine or ten days.

Ligature and suture. The preparation is same as outlined above. Two methods of suturing are in vogue, according to Jones and Thomas, and Mitchell. Jones and Thomas used a clamp, placing it longitudinally at the base of the pile, excising it and leaving a stump of about one-eighth of an inch. This is sutured with sterilized silk and the clamp removed. Mitchell's method is somewhat different. The suture includes the clamp and is continuous, being tied above and below after removal of clamp, drawing it taut, so as to approximate the edges of the wound.

Clamp and cautery. This is an old-time procedure, perfected by H. Smith. Preparation is the same as mentioned above. The pile is seized with volsellum and elevated, clamp being placed so as to include base of pile; the portion above clamp is excised with blunt scissors, the flat being next to the clamp; the remaining stump is cauterized with Paqueline cautery at dull red heat, care being taken to heat more if cautery sticks.

Loosen clamp a little to see if there remains any bleeding point, and if so, apply cautery again. Danger of this method is secondary hemorrhage and greater contraction.

Whitehead's operation is the one least used, because it is adapted only for the sessile type, or where the entire lower surface is a pile-bearing region.

This operation is the removal of the mucus and submucus tissue for two inches, including the entire canal.

The tissue is divided at the juncture of skin and mucus membrane and separated for two inches with blunt dissector down to sphincter. The mucus membrane is seized by four forceps equidistant and tension hand made on these during dissection. The tissue when dissected and drawn down is divided, and the circumferences of the cut surfaces are approximated with ligatures very closely set, including sufficient tissue to prevent tearing out.

This operation is not as successful as the above mentioned ones, as there is so much tension and ordinarily stricture re-

sults. It is indicated more when there is prolapse and a large pile bearing area.

The complications and sequels are several. There may result from any of these operations mentioned, sloughing with oval fistulas, abscess, hemorrhage, contraction or stricture, loss of sensation and often of control.

If this paper is the means of the patient's receiving closer examination, and relief, from this powerful and troublesome affliction of humanity, I shall feel that I am well paid for presenting it to the society.

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*THE WATER CURE FOR SNAKE BITE.

A. L. CHAPMAN M.D.,
LYON.

In presenting this paper I am leaving out all recorded facts, except a very few that are strikingly suggestive, pertaining to snake venoms, their chemistry, physiology and treatment. And I am not making any claim to originality. I am giving you facts that were discovered by accident.

About eighty years ago two boys went to drive some hogs out of a field and while near a spring branch a rattle-snake bit one of them on the foot. As the branch ran from toward home, and that being the best walking for bare-footed boys, they waded the water. When they came to the end of the branch the pain was so great that the boy went back to the water, and relief being instant he decided to stay while the other boy went to tell the folks. The father came and found the boy doing so well that he kept him there all the rest of the day. When he left the water this time there was no swelling, no malaise and no destruction of tissue followed.

About fifty years later the other fellow was bitten by a water moccasin and he immersed his wound in a basin of water for several hours with the result that there was no discomfort at any time after beginning the use of the water.

During August 1910, a man came to my office who had come about twelve miles, which had taken him about two hours to accomplish. He said he had been bitten by a highland moccasin and I found his hand and arm so badly swollen up to a band just below the elbow that I applied one further and cut

*Read before the Clarksdale and Six Counties Medical Society.

his loose. All this while he was on the verge of vomiting, and seemed about to collapse.

As soon as the bandage was applied I had him immerse his hand and arm in a bucket of water, and made an incision through the fang wounds. After a very few minutes he seemed so much better that it was like magic, but I kept him there for three hours, then bandaged the hand with cotton saturated with water and sent him home. He reported that he slept through the night without any disturbance, by morning all the swelling was gone and the knife-cut was the only distnrbing feature, that healing like any ordinary little cut.

Mitchell and Reichert in 1886, separated several active principles from rattle-snake, copper head, water moccasin and cobra venoms; and they found that some of the poisonous principles were water soluble. That may be one reason for the pleasing effect of water on these wounds. Another may be that the water favors elimination of the venom and its products by preventing coagulation of the blood—there is continuons bleeding.

Noguchi has divided the principles of venom into seven distinct parts and one of these is the hemorrhagic principle. That would account for some bleeding, but there was more bleeding after the beginning of the use of water.

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*A PECULIAR FOETUS.

J. A. DAVIS M.D.,

DOCKERY.

Mrs. J., aged 28, native of Missouri, weight 135 pounds, of fine figure, had no history of illness during girlhood. She has been married seven years and has suffered somewhat since marriage from dysmenorrhea. She has also had repeated attacks of malaria in the past seven years.

On May 31st. 1911, I had Dr. Johnson of Yazoo City to drain her gall bladder, and at the same time he dilated the cervix and did a thorough curettage. She returned on June 14th. 1911, the wound draining freely, so much so that I had it to dress daily for ten days.

On the night of her arrival home June 14th., she did the sexual act, and for several nights in succession.

On March 1st. 1912, at 3 a. m., I was called to attend her

* Read before the Clarksdale and Six Counties Medical Society.

in confinement. At 6:30 a. m. the head was born. As is my practice, I assured myself that the cord was not around the neck. With the next pain the baby was born, and my hand came in contact with what I thought to be abnormally developed male sexual organs, but which on closer examination, I found to be loops of the gut through an opening in the belly wall one inch to left of the umbilicus. I found the colon, a well-developed appendix, a kidney, the jejunum and a few other things hanging out.

On the instep of the right foot was a well-developed thumb. On the left foot was an abnormally developed great toe and a little toe, no others intervening. This was a girl baby and lived twenty-one hours.

Did maternal impressions have any influence on the growth of this fœtus? Did the operation influence fœtal life?

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*A CONSIDERATION OF THE MOST COMMON DISEASES OF THE TONSILS AND TREATMENT OF SAME.

HUGH L. MURPHY M.D.,

ARKABUTLA.

In my opinion tonsillitis is one of the most common diseases we are called upon to treat. The fact that we frequently overlook this, or the real, trouble, with our patient, when we are called to many cases, is unquestionably true. We find diseases of the tonsils more frequently among children, but by no means is it confined exclusively to childhood.

Tonsillitis is frequently associated with the specific fevers. The chief causes of all forms of tonsillitis are the local impairment of the epithelium of the crypts and their invasion by certain pathogenic bacteria. We find some of these cases, however, to be of rheumatic origin.

The first type to be discussed is the follicular or lacular. In this we have the acute and chronic forms. In the acute, the onset is sudden and is attended by malaise and fever. Chilly sensations and rigors frequently mark the attack. The temperature rises to 102 or 3° F. during the first forty-eight hours, and in very young children to 104 or 5° F. The febrile stage is accompanied by soreness, on swallowing, which may last for several days. On examining the mouth and throat during the

*Read before the Tate County Medical Society.

first twenty-four hours we find the tongue coated with a thick yellowish brown fur, the tonsils swollen and very red, later the tonsils become more swollen and a creamy discharge exudes from the mouths of the crypts. This discharge is not a true membrane, as in diphtheria and should not be mistaken for such, but this mistake is often made.

The prognosis in these cases is good, attacks lasting from five to eight days.

In the chronic lacular form, the symptoms are mild in character. The crypts of the tonsils are filled with caseous material, such as fatty matter, lenkocytes, and the like. The tonsils are usually very much hypertrophied; patient complains of neuralgic pain running to the ear. They seldom consult a physician until some of these caseous masses have been coughed up. "The prognosis is good."

The next affection of the tonsils to be considered—and the next in frequency—is peri-tonsillitis or quinsy. This form is very common in young adults and rare in children. The causation is about the same as in the acute lacular type.

The onset is gradual, if it has not been preceded by an attack of acute lacular tonsillitis with its sudden onset. The temperature is low, rarely exceeding 100° F. The pain increases with the extension of the purulent accumulation, until it is almost unbearable. Both sides of the throat are seldom affected at the same time. The muscles of mastication are affected and the opening of the mouth sufficient to permit an examination of the throat is very painful. At the beginning of the attack we find redness and slight swelling of one side, but as the disease progresses, the redness, pain and swelling increase, and on examination we find a considerable mass protruding from the affected side. This mass is frequently the anterior portion of the tonsil pushed forward against the pillar by the pus behind the tonsil. An incision in this region often fails to reach the pus for this reason. The soft palate and uvula are nearly always red and swollen. "The prognosis is good."

The next in frequency of the diseases of the tonsils is the hypertrophied tonsil, and since this is so closely akin to chronic lacular tonsillitis, I shall not dwell upon it.

Since many cases of tonsillitis are of rheumatic origin, I administer salol to the majority of patients. Elimination through all the emunctories is important in treating any form of tonsillitis. The diet should be light, consisting principally

of liquids. The acute lacular type is more amenable to treatment than any other form. I treat all my cases by applying a seventy-five per cent. solution of nitrate of silver to the affected tonsil. I have seen remarkable results in twenty-four hours from one such application.

On first seeing my patient I administer a purgative, usually calomel, and quinine in some form. If the fever is high and pulse very rapid, I administer a dose of tincture aconite and spirits of nitre every two hours, until temperature declines, the size of dose depending on the age of the patient. If the patient is subject to repeated attacks of lacular tonsillitis, a tonsilectomy should be done after the inflammation subsides. As to treatment of chronic lacular tonsillitis, will say that to remove the entire tonsil with capsule is the only satisfactory treatment, but if patient will not submit to an operation, I apply a seventy-five per cent. solution silver nitrate and prepare a gargle of listerine and peroxide of hydrogen, 25 per cent. of each in water to be used several times during the day.

In the beginning of an attack of peri-tonsillitis or quinsy, cold applications are indicated, applied to the neck and jaw, but usually by the time a physician is called to a case hot applications are called for. I apply hot flaxseed meal poultices or hot mush poultices, and direct patient to gargle throat every three hours with same gargle as prescribed for chronic lacular tonsillitis, with the hope of clearing the tonsil and surrounding tissues of all mucus and particles of food.

When the pus is established its evacuation is necessary, the location for the incision being determined by the operator.

The treatment of hypertrophied tonsils is entirely surgical. In a child under eight years of age a tonsillotomy may be done, but if older, an tonsillectomy should always be done in preference to tonsillotomy.

To recapitulate: many cases of tonsillitis are overlooked by the general practitioner. The tonsils are the seat of much trouble; always examine the throat when you are called to see a child with high fever and rapid pulse, unless you can positively locate the trouble somewhere else.

In treating all forms of tonsillitis, elimination is important. A strong solution of nitrate silver applied to the affected tonsil is the best application in most cases.

A tonsillectomy is always preferable to a tonsillotomy; the tonsillotome should, under no circumstances be used except in young children.

State Fair.

The letter sent out by the committee on Woman's Day for the Mississippi State Fair is as follows:

To the Women of Mississippi:

Wednesday, October 23rd. has been designated by the management of the Mississippi State Fair as Woman's Day and the co-operation of every woman in the state is earnestly desired to make this the greatest day of Fair week.

The women of Mississippi have always been interested in every movement involving the welfare of the state and the management of the State Fair of 1912 has courteously agreed to a plan to set aside each year a day as Woman's Day.

Let every woman prove her love and pride in the old Magnolia State by her enthusiastic encouragement and co-operation and determine that success shall crown this undertaking.

This can only be obtained by all of our women being equally interested and we invite the co-operation of all women's clubs throughout the state—all benevolent, charitable societies—social, literary, musical, art, patriotic clubs. We ask that the president or secretary of each club, etc., communicate with the Chairman of Woman's Day Committee through the Secretary, Mrs. J. R. Lane, 769 North President Street, Jackson, Miss.

Any plans or suggestions to make this day an attractive and beneficial one will be most gratefully received. The special feature of the day, the Committee hopes, may be an address by Governor Woodrow Wilson (our next President.) There will be other addresses by brilliant speakers.

The Chairman of Woman's Day Committee and the management of the State Fair will especially appreciate prompt attention to this invitation and will thank you for your interest.

Most cordially yours,

MARY ROBINSON WILLIAMSON,
(Mrs. Chalmers Meek Williamson)
Chairman Woman's Day Committee.

Masotti, *Quinzaine therapeutique*, finds carbon dioxide snow especially useful for small pigmented nævi. Good results were also to be obtained by the use of this agent in keloid growths, senile warts and lupus.—*New York Medical Journal.*

MISSISSIPPI MEDICAL MONTHLY.

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OFFICIAL ORGAN OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION AND ITS COMPONENT SOCIETIES.

SUBSCRIPTION ONE DOLLAR PER ANNUM.

The Secretary A. M. A. is arranging a meeting of the state secretaries to discuss questions of uniform membership. By the plan proposed a member of any state association, moving to another state, becomes a member of the association of the state of his new location upon presentation of a demit from his former state secretary. Dues, having been paid in the first state, shall not be required in the second.

At first glance this seems right and proper. There would be practically no financial loss anywhere, since men moving into a new place late in the year rarely affiliate with the state association until the new year, and the loss is really the association's when this happens since a new member is worth more to the association than the few dollars he contributes to its treasury. Thus the financial part can be easily settled, but to the Southerner the question immediately presents itself: "What of the colored brother?" We are informed, it may be incorrectly, that some of the state associations admit negroes to membership. If this be true they must be gotten rid of and the laws of the A. M. A. must be re-written before any Southern state can accept a charter from it. At present there is nothing in the constitution of the A. M. A. to prevent any state from taking in such members and the by-laws already provide for a transfer of membership on the plan proposed. So far as Mississippi is concerned such method of obtaining membership has not been attempted by anyone, certainly within the past five years. And as to the negro, the Mississippi Association has

written into its law that to become a member the applicant must be licensed, reputable and white.

It may be that we are "barking at a knot" but in the light of the recent experience of the American Bar Association we cannot be too careful.

Persons of the male sex, who find themselves hypersensitive to modern dances like the turkey trot, the glide, etc., as well as to the becoming apparel of young women, should have themselves tested for subacute prostatitis. The passage of large steel sounds will often disclose to the surprised moralist a simple physical basis for his scruples. Angry remonstrances from the other sex may depend upon an absence of graceful agility or upon facial or physical deficiencies. The dances in question require great physical endurance and, upon the performers at least, have an effect precisely opposite to that imagined by certain alarmed spectators.—*N. Y. Medical Journal.*

The erudite and philosophic business manager of the *Monthly* sat at his desk and scrutinized the subscription list. "If it be true," he mused, as he ran his fingers through the luxuriant hirsute growth that covers his sagittal suture, "that men who squeeze the dollar never squeeze their wives, there are a number of doctors' wives in this state who are not getting what is coming to them."

Notices.

Dr. H. F. Garrison of Seminary has been appointed councilor of the eight district to succeed Dr. G. W. Wallace of Arbo who has moved to New Orleans.

"Professor Dr. H. Strauss of Berlin will lecture at the New York Post-Graduate Medical School and Hospital, Second Avenue and Twentieth Street, on October 12th., 14th. and 15th., on the Diseases of the Stomach and Kidney. Professor Dr. Carl von Noorden, Physician in Chief to the City Hospital, Frankfort, Germany, will also deliver a series of lectures on the Pathology and Treatment of Diabetes, Radium Therapy and Arteriosclerosis at the same place, on October 28th. to October 31st., inclusive."

Obituary.

Thomas Jefferson Mitchell was born July 4th. 1830 near Huntsville, Ala., and died at Jackson, Miss., Sept. 16th. 1912. He was of North Carolina and Virginia stock. Entering the University of Alabama for academic education, he received his degree in 1849 and transferred his field of study to the University of Pennsylvania, from which institution he was graduated with the M.D. degree in 1852. The year following he spent in Paris, attending lectures at the hospitals and giving special attention to that line of medicine in which he was so justly noted in later years. He settled in Jackson on his return to America and there, in 1858, he married Miss Annie McWillie, daughter of Governor McWillie. Of this union were born eight children.

At the outbreak of the civil war Dr. Mitchell was commissioned surgeon and assigned duty with the 39th. Mississippi, with which command he served throughout the war. At its close he returned to Jackson, where he remained the rest of his life.

Dr. Mitchell was successively city physician of Jackson, penitentiary physician and, finally, superintendent of the State Insane Hospital, which last office he held from 1878 to 1910. He was chosen president of the Mississippi State Medical Association in 1904.

Book Reviews.

PELLAGRA—History, Distribution, Diagnosis, Prognosis, Treatment, Etiology—By Stewart R. Roberts M.S., M.D., Associate Professor of Principles and Practice of Medicine, Atlanta College Physicians and Surgeons; C. V. Mosby Co., St. Louis, 1912. Price $2.50.

The author in his preface touches the kernel of the Pellagra situation when he says: "There has been too much speculation on Pellagra and entirely too little investigation of the disease." This work is evidently an earnest study of the disease based not only upon American experience, but upon extensive investigation in Italy, and as such is the most up-to-date work on the interesting subject. The author follows the classic division into acute Pellagra, sub-Chronic and Chronic forms and every chapter is full and very interestingly written. In fact, no medical author of recent years has as pleasing a narrative style, which makes this work as fascinating as a novel.

Very properly, the author places the Etiology last, since as he correctly says that as the cause is unknown at present, it would be folly to place Etiology first as is customary and base a system of treatment, etc., upon

false premises. It is true, as he says, that a theory is one thing, and its proof another. We have numerous theories and little proof. He discusses in detail whether Pellagra is an intoxication or an infectious disease. Except for the fact that on the map Mississippi is shown to be highly infected with Pellagra and is estimated to have 2,000 cases, both of which statements, we believe from experience to be exaggerated, the book is candid, sensible and ought to be of great assistance to any one grappling with this formidable scourge.

S. MYERS.

INFANT FEEDING. By Clifford G. Grulee A.M., M.D., Assistant Professor of Pediatrics at Rush Medical College, Attending Pediatrician to Cook County Hospital. Octavo of 295 pages, illustrated. Philadelphia and London: W. B. Saunders Company, 1912. Cloth, $3.00 net.

Dr. Grulee's book is based on a course of lectures given to the students of Rush Medical College for the past three years and differs from the majority of works of this class by Americans in that the author is a follower of the German schools. Percentage feeding is by no means perfect, but when an author directs for the feeding of an infant under one week old "3 ounces of a mixture of half-milk and half-water" the question immediately presents itself: "What kind of milk?" Or does the author really not recognize the fact that different kinds of cows give different kinds of milk? If such simple methods give the results desired the problem of infant feeding will lose all its worries, but the care-free way Dr. Grulee goes about it is enough to convince anyone that the story is not all told and the man who follows it without knowing the rest of the tale is liable to lay himself liable to the uncomplimentary definition of a physician, "a person who puts drugs about which he knows nothing into bodies of which he knows less."

E. F. HOWARD.

SEXUAL IMPOTENCE by Victor G. Vecki M.D., consulting Genito-Urinary Surgeon to the Mt. Zion Hospital, San Francisco. Fourth edition enlarged. W. B. Saunders Co., Philadelphia and London 1912. Price $2.25 net.

There are many questions upon which our advice as physicians is asked and which subjects have not even been mentioned in the college courses. Probably, if mentioned, so vaguely and hurriedly that memory is lost of it in the hurry of other and more important things. One of such subjects is Sexual Impotence which probably the lecturer on Genito-Urinary diseases dismisses with a few words as to tonic treatment and psychic influence. That this will not suit all cases, the young practitioner is apt to find out in his first month's practice. This work of Vecki on the subject of Sexual Impotence answers many questions and will repay study. For instance many are asked what is sexual excess, Vecki answers with the definition "as long as no unusual effort is required, no special means is made use of for rousing sexual passion and no feeling of fatigue or faintness is experienced, there is no excess."

The opinion of the author will shock many theoretical purists in some points, for he believes in the necessity of sexual intercourse; otherwise he believes power is lost. His views on continence must be abhorrent to all who believe in mortifying the flesh. Still, as a consultant of wide experience, and an author of wide reputation (this being the fourth edition of this work in twelve years) his views are entitled to mature consideration and are not to be dismissed simply because at variance with our inculcated religious beliefs. The work is one that every broadminded physician should possess.

S. MYERS.

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*REPORT OF CASE OF PENETRATING GUN-SHOT WOUND OF THE CHEST.

M. J. ALEXANDER M.D.,
TUNICA.

On the morning of Feb. 15th. 1912, I was summoned hastily to see T. W., a white man, aged about forty-five years, who, while cleaning a thirty-eight-calibre Colt's revolver, accidently discharged the same, the ball entering the chest at a point about one inch to the right and three-quarters inch below the left nipple, passing through the chest and out just to the left of the fifth dorsal vertebra. When the accident occurred the muzzle of the pistol was held so close to the body that the clothes were set afire, and although the same were promptly put out by the injured man, a burn, the size of a half dollar silver piece was sustained about two inches above the wound of entrance, which latter was intensely black from a concentrated powder-burn.

I reached him about half an hour after the accident and found him on his bed, surrounded by a large number of friends and relatives, who expected him momentarily to fall over a corpse, on account of the belief that the shot had undoubtedly wounded his heart. The patient himself was naturally very much excited, complaining of inability to see and a numbness in the left arm.

There had been only moderate hemorrhage from the wound of entrance before my arrival and afterwards there was slight discharge of venous blood when he was raised in a sitting position. There was little cough, but this was extremely painful. I at once administered a hypodermic of a quarter grain morphine sulphate and proceeded with the preparation of the patient for proper dressing. The wounds and a large area surrounding them were thoroughly cleansed and washed

*Read before the Clarksdale and Six Counties Medical Society.

with one-two-thousandth bi-chloride solution, followed by alcohol, and covered with thick pads of ganze and absorbent cotton. No effort was made to get rid of the black powder-burn in the wound of entrance. Dr. Hitt, the patient's family physician, arrived soon after completion of dressing and together we laid out a plan of treatment. The question of drainage was disposed of by a plan of "*noli me tangere*" treatment. After the dressings were completed a recumbent position was strictly enjoined and two nurses placed in charge of the case.

The subsequent treatment consisted of one-eighth grain morphine when pain, cough or restlessness should demand it. Small amounts of cold water or crushed ice were given *ad libitum*, together with a regulated strictly liquid diet. For the first five or six days the dressings were renewed daily, the same as at the beginning; after that, every second day.

Aside from a few drops of bloody serum from the posterior wound on the second day, there was absolutely no discharge from either wound which were kept hermetically sealed, the anterior one by the black plug produced by the powder-burn, and the wound of exit by the union of the several parts.

On the second and third day the temperature did not rise above 100° F.; the pulse rate, however, went on those days to one hundred and twenty-four and one hundred and thirty, but this was attributed to considerable tympanites and difficulty in micturition, the latter no doubt caused by the frequent use of the narcotic. After the use of the catheter for several days, the normal action of the bladder was re-established. The tympanites was relieved by high flatus enemeta, being repeated once a day, and entirely controlled by minute doses of calomel. The appetite throughout the time of his confinement was good and any addition to the bill of fare as convalescence progressed was hailed with delight. After the fifth day the temperature remained virtually normal, the pulse being only slightly accellerated.

On the twelfth day after the injury the patient was allowed to leave the bed and a week later was able to go to his office, and is now apparently in perfect health. I report this case, not because it is an unusual one or to claim any credit whatever for special skill in its treatment, but to emphasize the fact that in the majority of these gunshot injuries active surgical interference should not be attempted, unless circumstances urgently demand it.

The prognosis of penetrating gunshot wounds of the chest depends largely upon the amount of hemorrhage, both as to immediate and remote results. Of course injuries to the heart and large vessels are usually promptly fatal. If the hemorrhage is not sufficient to cause death primarily, it may be enough to exert fatal pressure upon the organs. I believe, however, that it is the experience of army-surgeons that many recover even after considerable hemorrhage; large quantities of blood entering the pleural cavity, to be, in the course of time, absorbed.

As stated before, this case was treated by the closed method all the way through, nothing being done to assist drainage, except what the recumbent position might favor from the wound in the back, which was practically *nil*.

Many of my patient's friends seemed interested in the wounds and frequently inquired whether drainage was sufficiently free and seemed rather skeptical when I explained to them that the proper treatment was to keep the wounds closed, and that interference would tend to irritate and possibly infect them and would unnecessarily disturb the patient.

And it is a fact that modern ammunition only in the rarest of cases will carry foreign matter or pathogenic germs into the body, nor is there as much laceration of tissue along the path of the steel bullet as there was when lead was the material used.

In this case, as remarked, there was not much cough. The expectorations were bloody, but not profuse, clearing up on about the eighth day. No symptoms of traumatic pneumonia showed up and no ice or cold packs were used to prevent. I doubt that this would have been good treatment or that it is as useful to prevent a possible inflammation as it would be to subdue it. My experience has been that traumatic pneumonia of serious nature develops only in a certain per cent. of cases, and mostly those who receive too much treatment.

My patient was a spare-made man, with no surplus flesh; in fact rather thin, and this condition, I believe, was a great point in his favor, as far as the ultimate result was concerned. Before closing, I cannot refrain from remarking on the numerous apparently miraculous escapes from injury to the many large blood-vessels, when the bullet evidently travels toward them; the latter seeming to pick its way among them as it were. No doubt elasticity of these vessels often saves them from seemingly inevitable injury.

*PERIOSTITIS ALBUMINOSA.

C. D. DAVIS M.D.,
McCONDY.

As periostitis albuminosa is quite a rare manifestation of bone disease, I concluded it might be of interest to the society to give the history of a case operated on by Dr. Brand and myself, together with a description of the operation.

Before giving the history, however, I will attempt a description of the disease.

Most text-books are silent or very brief on this particular form of periostitis, consequently my information gleaned from this source is meagre.

Ollier first distinguished it in 1868 and since then it has been a subject of controversy.

Periostitis albuminosa is a condition less acute than infectious periostitis.

The subperiosteal collection of fluid is gelatinous or mucoid in appearance rather than purulent, which suggested the name received in time past. It has but recently been regarded as a variety of the infectious form of periostitis in which the products of exudation assume the serous rather than the purulent type.

It appears to be the tubercle bacillus that is at fault in some instances.

The organisms producing the disease are more or less virulent else, as said by Park, the clinical form of the malady would be less serious than it really is. Cultures made from the subperiosteal collections have demonstrated the presence of some one of the many pyogenic organisms.

Dor has described a microbe found in this disorder, which he called the bacillus cerius citrins, with which he produced the disease in animals.

The disorder generally is localized in but one bone, which was the case with the patient whose history I will now give.

Examination for the first time was made at my office in the early part of June 1908.

The patient, a negro woman, about twenty-two years old, said she bruised her leg five years prior to this time, which caused some swelling. She stated that the limb was more painful at night. She could work in the field but could not make a first-class hand. She had a chill and several days of

*Read before the East Mississippi Four County Medical Society.

fever three months before this examination and was treated for malarial fever.

I found her general health fair. There was no history of syphilis or tuberculosis.

Three tumors, each the size of a baseball appeared in a row on the lower two-thirds of the internal or subcutaneous surface of the left tibia.

By aspiration, I discovered the tumors were cystic, all containing a gelatinous fluid too thick for much to be removed through an aspirating needle.

The middle tumor contained a large amount of pus together with the gelatinous material common to all. A small fistulous opening was in this enlargement, which had been running scantily for three months. A slight wound might have caused this opening and allowed the entrance of pus germs. This infection could have been responsible for the chill and fever above mentioned.

The upper tumor contained a grayish flocculent gelatinous fluid and the contents of the lower tumor was the same except in color, which was that of blood from an old hemorrhage.

There were no openings, fistulous or otherwise, between the tumors, though they were in close contiguity—a fact suggested by the difference in the color of the contents and afterwards demonstrated in the operation.

On June 13th. of this same year, Dr. Brand and I met at the patient's cabin and decided to operate. She was anæsthetized with chloroform. An incision was made nearly the whole length of the tibia, through the tumors to the bone. The contents were evacuated and the thickened vascular periosteum, which formed the inside walls, was torn and dissected out together with the adipo-fibrous tissue which helped to make up the growths.

The base of each tumor was the denuded bone, measuring from one to one and a quarter square inches.

The bone was scraped and chiseled thoroughly until a perfectly smooth healthy surface was obtained.

A strip of skin, three-fourths of an inch wide, was removed from the inner side of the whole length of the incision as it was redundant.

The wound was closed in the usual manner except that a sufficient opening was left over the site of each tumor for the purpose of drainage. These openings were packed with iodoform gauze and an antiseptic dressing applied.

As there was considerable capillary hemorrhage, a rubber compress bandage was worn for twenty-four hours. Dry dressing and gauze packing were reapplied each day until a complete recovery took place, which was about two months from the date of operation.

*MY OBSERVATIONS IN TWENTY-FIVE ADMINISTRATIONS OF SALVARSAN AND NEO-SALVARSAN.

T. B. LEWIS M.D.,
GREENVILLE.

Only a few years ago we read with delight of the discovery or rather of the identification of the spirochete pallida and this was soon followed by the announcement that the great German chemist and investigator had perfected a chemical, one dose of which would entirely eradicate syphilis from the system, regardless of its form or stage of malignancy. The enthusiasm thus created was of rather short duration in the minds of most thinking men and clinical evidence soon determined that it was not final in fighting this loathsome disease. In some cases this enthusiasm actually did harm when great hopes were blasted by its failure to cure the hopeful.

Then there came a stage of its existence when many of its enthusiastic admirers almost or entirely doubted its worth, some actually stopped its administration and have never taken it up again.

Following this stage of doubt we seem to have struck a happy medium. We now no longer claim a positive cure in any stage of the disease and while we realize fully that we have much yet to learn about salvarsan, we do know that in it we have a wonderful adjunct to our old line of treatment. We know that distressing symptoms, the relief of which would require weeks or months with mercury and the iodides, will fade away in from three to ten days under the influence of a dose of salvarsan. As to the best method of administration there is yet a good deal of difference of opinion, many good men, among whom I will mention Dr. Murphy of Chicago, leaning toward the intramuscular method, claiming for this method a slower entry into the blood and a more protracted and efficient action than when the whole amount is thrown at once directly into the blood-stream. Reasoning along this line I notice that

* Read before the Washington County Medical Society.

some men are now dividing the dose into six parts of one-tenth each and giving one part each day in alternating sides of the buttocks. This is, of course, less painful and seems to me preferable to forcing the whole dose into the muscles at one sitting.

Extreme pain, non-absorption, abscess formation, and sloughing are the principal objections to the hypodermic or intramuscular form of administration, however most of these except the pain can be eliminated by giving only an intelligently mixed dose. It must be aseptic, in perfect suspension and of absolutely neutral reaction.

The results so far in every case except one of our twenty-five administrations have been very satisfactory indeed, the exception being probably a mistaken diagnosis and in this case if there were any permanent ill results we failed to note them. Our plan is to have the patient in the hospital, preferably a few hours prior to the administration, stomach and bowels empty, temperature and pulse noted, operating room and patient prepared as for any important operation and the dose given directly into the vein. Right here I will state that it pays to select a vein large enough to work with.

It has been our plan to close the opening in the vein with fine catgut, thus preserving its lumen.

The patient is put to bed for at least twenty to forty-eight hours, temperature and pulse being taken every hour for five or six hours and then less often. In this way we have been able to pretty closely watch the immediate effects in every case. Barring the one case mentioned, we have had a typical reaction after each administration. In my opinion a reaction doesn't necessarily mean a rigor; however, we have noted a rigor in about half of our cases. The rigor in all probability is not entirely due to the drug but to some impurities in the water or to some slight mistake in the preparation. It is very important that it be of absolutely neutral reaction. One of our cases, a middle-aged man of good habits and above the average in intelligence, developed a chancre about three years ago and began active treatment as soon as the diagnosis was confirmed. He received hypodermic mercury besides the ordinary internal treatment for two years and I feel no hesitancy in saying that he followed directions scrupulously, as he realized his plight and wanted to get well. While there had been very little evidence of progress or external manifestations of the disease, yet he had shown at all times plainly that he was not

getting well, that the treatment was not doing what it should do under ordinary conditions.

During the past ten months he has received five doses of salvarsan. The reaction following each administration as shown by the temperature chart has gradually decreased, at first going to 103.5° F., and after his last dose which was given two weeks ago he had a very slight reaction, his temperature just reaching 100 and gradually coming back to normal four hours later. He has shown marked relief from symptoms after each administration and now seems entirely well, though of course it is too early to state positively the final results.

Another young man, following the development of a chancre, was treated persistently and intelligently for two years with mercury and the iodides.

About the latter part of last year he developed a lesion on the side of the tongue which persistently increased in size in spite of antisyphilitic treatment. It was so persistent that malignancy was suspected and he was sent to a pathologist in Memphis for microscopical examination. At this time the lesion was three-quarters of an inch wide and one and one-half inches long, angry in appearance and quite painful. Under the influence of salvarsan the lesion healed entirely in less than two weeks, along with the clearing up of all other symptoms. These cases, as well as all the rest of ours, are kept on mercury just the same as before giving salvarsan.

Three things I consider very important in the use of salvarsan: carefully determine that it is indicated, *i. e.* find cases that do not respond to the ordinary treatment or some condition in which quick effect is desired; know how to do an aseptic operation; and carefully mix the drug and administer it at the proper temperature, excluding all air from your apparatus.

We find that neosalvarsan, as is stated in the folder included in each package, is less complicated to mix, hence less liable to become non-sterile in the mixing, has less unpleasant after-effects and that it is fully as active in its effects.

Contra-indications and dangers I agree are many, and time may reveal many that we as yet know nothing of, yet I feel safe in saying that in well-selected cases the positive indications outweigh the danger and contra-indications just as much as they do in considering the removal of an inflamed appendix.

As stated early in this paper, we consider the new drug only a valuable adjunct and in no case do we discontinue the old line of treatment.

*REPORTS OF CASES.

THOS. F. WILLSON M.D.,
ARCOLA.

The following cases are of interest because they show that a woman may have all the signs and symptoms of cancer of the uterus and not have cancer. To make a diagnosis without the aid of the pathologist is unwise and unjustifiable. It is unwise and unwarrantable to operate or to advise an operation unless a positive diagnosis can be made.

Without discussing cancer of the uterus at all, I wish to report these cases:

Mrs. P., age about forty-five, multipara, passed the menopause. At the time of my visit she complained of leucorrhea and loss of blood. She was weak, pale and anaemic; confined to her bed most of the time. There was some pain in the lower part of her abdomen. Vaginal examination revealed an enlarged, indurated, bleeding and eroded cervix with an offensive discharge. The vagina seemed to be involved. On these symptoms I made a "positive" diagnosis of cancer of the uterus. Advised an operation but my advice was not taken. I saw this woman last fall, four years after my first visit, and she looked the picture of health. I did not make a vaginal examination, so don't know the condition of the uterus.

Mrs. J., age forty, mother of three children. Was consulted for leucorrhea. Vaginal examination showed an enlarged, hard and eroded cervix which bled freely upon the slightest touch. The general health of this patient was poor. Local treatment was given. Examination about a year afterwards showed no signs of the old trouble.

Mrs. P., age thirty, mother of six children, presented all the symptoms of beginning cancer of the cervix. Under local treatment all symptoms disappeared and the cervix looks as healthy now two years afterwards as ever.

Mrs. W., age thirty-eight, multipara, three years ago presented all the symptoms, both local and general, of advanced cancer of the uterus. This case was seen by several physicians. All told her that the only hope she had was in an immediate operation. I saw this lady about ten days ago and she looked that she was never in better health in her life.

I could cite at least a dozen other cases like the fore-

*Read before the Washington County Medical Society, July 3rd., 1912.

going in which time has cleared up the diagnosis, but would be a repetition.

In reporting these cases, the point I wish to make is that a diagnosis cannot be made without the microscope. It does not matter if the woman has passed the menopause and has all the symptoms of cancer; you are not justified in operating unless the diagnosis is confirmed by the pathologist. Please do not misunderstand me, I do believe in early operation and think it is the only thing to do, but all cases that look like cancer of the uterus are not cancer by any means.

*REPORT OF A CASE OF DIABETES IN A CHILD EIGHT YEARS OF AGE.

J. W. THOMPSON M.D.,
INDEPENDENCE.

Doctors usually report cases that make "an uneventful recovery" but I shall report one that died, and in doing so shall not discuss nor attempt to make clear any of the adduced theories of diabetes. I report the case because it is an interesting one, since the disease is infrequent in children under ten years of age.

Pavy collected thirteen hundred and sixty cases of diabetes in children and it occurred in only eight under ten years. It occurred under this age but once in a series of seven hundred cases collected by Prout and but once in three hundred and eighty cases collected by Myer. This shows the infrequency of the disease in young children.

In these reports, several of the cases had been preceded by injuries to the head. The case I am about to report received such an injury about six weeks before he died. He fell on the ice and frozen ground and received a cut about half an inch long in the skin of the forehead. After a few days, three or four, the wound showed signs of infection, some suppuration, and there was an inflammatory zone around the wound, but there was no fever. I lifted the scab, evacuated what little pus was there and applied a little iodine. The wound was soon well and I heard no more from the child for nearly six weeks.

One night about ten o'clock I was called to see him and found his breathing rapid and shallow, about seventy to the minute, pulse one hundred and thirty, and temperature sub-

*Read before the Tate County Medical Society.

normal. Since receiving the injury he had, as they said "been going down hill," had lost fifteen pounds or more in six weeks, had a voracious appetite and intense thirst, and, from what the family said, must have voided at least a gallon of urine in the twenty-four hours.

I gave one one-houndred-and-twentieth strychnine and one three-hundredeth atropine every four hours, but was called the next morning at five o'clock and found him comatose.

I made an examination of the urine and found specific gravity 1.035 and sugar present; no quantitative analysis was made.

Stimulate and elimination were continued, but the child died in about twenty-four hours in what I thought to be diabetic coma.

Whether the injury to the head was an etiological factor I cannot be positive, but since Osler mentions cases of diabetes following mental shock as well as injuries to the brain or spinal cord, I believe it was a causative factor, as his previous health had been good and symptoms did not appear until after the injury.

Osler divides cases into dietetic, pancreatic and neurotic, the last being due to injuries or functional disorders of the central nervous system, so we might account for injuries precipitating an attack of diabetes by imagining some perivascular change being produced, or perhaps a thrombus or some functional disorder of the brain caused by the injury, which in some way interfered with the normal metabolic processes.

There is a volume of pathology and physiological chemistry untold in this paper but it is not my purpose to discuss the different theories of diabetes, about which so much has been written, and if the report induces us to read and investigate along this line no doubt it will serve a purpose.

*SOME OBSERVATIONS IN PNEUMONIA.

S. T. WELLS M.D.,
ALLIGATOR.

In writing this paper it is not my intention to burden you with a "text-book" description of the pathology, etiology, bacteriology and clinical course of this disease. Neither shall I offer anything new in the way of medication. What I particu-

* Read before the Clarksdale and Six Counties Medical Society.

larly wish to impress upon you is the "lack of medication" in the treatment of pneumonia. For several years there has been a growing tendency to less drug treatment in pneumonia and I think the results should encourage us still further along this line. We are learning to withhold the heart stimulants until the heart actually needs assistance and in the majority of cases I find they are not required at all. The habit of giving digitalis and alcohol in the early stages of pneuomnia should be condemned. Even should they be required at all, it will be in the later stage when the heart is beginning to show fatigue. In this condition of course, they should be used and for effect. Antiphyretic drugs have no place in the treatment of pneumonia. In white patients the bath is, of course, to be used, but is a very unwelcome mode of treatment for a negro, who feels far more comfortable with a temperature of 105° F. than would a white patient with a temperature of 102. In hospital practice I have noticed the constant objection to bathing on the part of negro patients in all conditions. So I believe the beneficial effects of bathing as a means to reduce fever in negroes is more than overbalanced by the worry caused by knowing they must be bathed. In private practice I let the fever take care of itself, and rarely have a patient complain of it.

For pain, blisters are not resorted to as they once were. Personally I never use this method of treatment for I never saw any benefit derived from a blister.

If the application is allowed to stay until the skin is irritated but not blistered, I can see no objections to its use.

Negroes are great believers in all local applications and the "old mammy" will often insist that she be allowed to put a "plaster" on her child. I usually do not object but instruct her to remove it just before a blister forms. Hot applications, as a hot water bottle, are more preferable. In severe pain, if necessary, I give morphine as it lasts only a short time and there is no danger of habit formation. The only objection to its use is the checking of secretions.

For cough I rarely find it necessary to give anything, especially as coughing is a necessary part of the disease. However, if necessary, it may be controlled by small doses of some preparation of opium. During the past year I treated twelve cases of pneumonia, all of which recovered; all except one without complications. All except one were young, ranging in age from twenty to thirty years, and in none of these was it necessary to use stimulants at any time.

In the one who was sixty-five years of age stimulants were necessary in the later stage as the heart was almost tired out when the crisis came. He soon responded to the use of strychnine and alcohol in the form of egg-nog. Here we have no place for digitalis as we want effects at once.

It has been my custom to first give calomel liberally, then quinine also liberally, keeping the patient cinchonized for from thirty-six to forty-eight hours.

After this I give potassium iodide with creosote in small doses every four to six hours throughout the course of disease. This iodide and cresote treatment was adopted, however, after being recommended by a writer in a prominent medical journal.

This treatment has been entirely satisfactory in these cases and I think we can assume at least that there is no harm likely to befall the patient from its use.

*WHOOPING-COUGH.

H. C. BUCK M.D.,
FRIARS POINT.

This disease, which Dr. Hare says is sometimes called pertussis, is said by writers on the subject to be a self-limited disease and they do not give any special time that it may remain; they say it lasts from three weeks to as many months and sometimes even a longer time. The history of the disease is not clear; the first accounts we have of it are in the year 1578. Writers on the subject say it may have been known to Hippocrates and Galen, but there is no mention of it in the writings of either of these ancient physicians.

Regarding the etiology of this disease all writers seem to agree that it is caused by a micro-organism, but according to Hare "No uniformity of opinion exists as to its specific organism." Again Hare says: "Whooping-cough so often occurs in close connection with an attack of measles that the two diseases must be regarded as nearly related."

Sajous says: "The clinical history of the disease points strongly to the existence of a specific organism to which catarrhal and nervous symptoms may be more or less directly attributed, but so far pathologists have not determined with certainty the exact micro-organism." After quoting from a number of writers he says: "Thus it appears that several micro-organisms have been found with sufficient regularity in the

*Read before the Clarksdale and Six Counties Medical Society

sputum of children suffering from pertussis to be regarded as the exciting cause, but at the present no one germ is recognized as such."

After reading the above I would say this disease is caused by "a germ" and place strong emphasis on the "a." We often hear it said: "There is nothing in a name." I remember when a student at college our professor on surgery, when talking to the class about "boils, said: "Now, gentlemen, when you go home and hang out your shingle, if a patient comes to you with a boil, I entreat you *not* to call it boil; if you do he will think he knows as well what to do for it as you, but look wise and say, my dear sir you have a furunculus; he will think it something serious and you will get a fee."

While whooping cough is looked upon by the laity as a simple disease and one not requiring the attention of a physician, pertussis is looked upon as a serious disease and one that requires the close attention of the physician; hence when called to a case of whooping-cough, we should look wise and say to the mother of the patient: "Madam, your child has pertussis"; for like the man with the boil, if we call it whooping-cough any old woman in the community can treat the case, but if it is pertussis it is best to have a doctor; hence I say, that often to the doctor there are dollars in a name.

In our journey through life there are many things that make an indelible impression upon our memory. Although many years have passed since I had this disease, I have never forgotten it's visitation, have never forgotten how whenever I felt I was going to cough I ran to a tree or fence to lean against during the "spell," and when there was neither tree nor fence near enough I threw myself upon the ground and coughed and "cussed" until I was almost exhausted. I am not prepared to say the "cussing" was any benefit, unless to relieve the nervous tension, nor do I wish to go on record as one who recommends it as a remedy in this disease. The use of this remedy, if it is a remedy, must be left to the option of each individual sufferer. It has been my misfortune during the present year to have to contend with an epidemic of whooping-cough. In my treatment of the disease I feel safe in saying there are few if any remedies the books recommend for this disease that I did not try. I feel equally safe in saying that if I found any one that did any more good than "cussing," I fail to remember its name; that is the remedies recommended in the books as being like "Carter's Little Pills," a "Dead Shot," hence I have come to the conclusion there is no cure for the disease. The

remedy that gave me most satisfactory results in the treatment was calcium sulphide, but I must admit that I only tried it in two cases. The first was an infant eight months old; as soon as the disease appeared in this case I put him on calcium sulphide, one-fourth grain every four hours during the day, and instructed the mother to keep his bowels open; this she did with "castoria." Although the child was teething, and cut four teeth during the time, he was only sick about two weeks and lost one pound in weight. The second case was a frail little girl, about two years old. As soon as I learned she had been exposed to the disease I put her on calcium sulphide, one-fourth grain every four hours during the day. However, I first thoroughly unloaded the bowels with small doses of calomel and podophyllin. While the treatment did not prevent nor cure the disease, and she had a moderate cough for four or five weeks, yet I feel sure it was beneficial as she never had a severe cough and her general health was not impaired in the least. While, as I said, she had a cough for several weeks, yet at no time did she have such severe paroxysms as are usually seen in such cases. From my experience with this remedy I think it is worth a further trial.

Society Proceedings.

Covington County Medical Society met Oct. 8th. and approved the suggestions for uniform membership offered by the American Medical Association. The annual meeting, for election of officers, will be held this year, as usual, in December, but the society stands ready to hold it in October in future provided the plan meets the approval of the State Association. The meeting was a good one; we are well in harness, "traces tight," everything working smoothly. After regular business we were entertained by Dr. J. H. Temple with his Medicophone Post-Graduate Machine.

H. F. Garrison,
Secretary.

Prentiss County Medical Society has elected officers for 1913 as follows: president, D. T. Price, Booneville; vice-president, S. L. Pharr, Marietta; secretary-treasurer, J. A. Hughes, Baldwyn; delegate, J. C. Vandiver, Wheeler; alternate delegate, W. V. Davis, Booneville.

Tate County Medical Society met at Arkabutla Oct. 2d. and elected officers for 1913 as follows: President, H. L. Mur-

phey, Arkabutla; vice-president, R. A. McReynolds, Strayhorn; secretary, J. S. Eason, Coldwater; treasrer, W. D. Smith, Senatobia. The censors are D. C. Le Verne, N. R. Hosey and J. J. McCauley—one, two and three years respectively. M. C. Ellis of Senatobia was elected delegate to the state association. The next meeting will be held at Coldwater, Wednesday, Nov. 6th.

W. D. Smith,
Secretary.

Tri-County (P. L. C.) Medical Society met at Brookhaven, October 1st., with the following members present: Arrington, Butler, Catching, Dickerson, Flowers, Jones, Johnson, Little, D. W. Magee, T. K. Magee, MeLeod, McRee and Drs. DeBerry, Doler and Higdon guests.

Only two papers were presented, one on Appendicitis by Dr. T. K. Magee, and one on Ulcer and Cancer of the Stomach by Dr. J. M. Catching, but they were quite enough to engage everybody for the whole time allotted to the meeting. Every phase of these important subjects was discussed, practically everybody taking part.

Four new applications for membership were filed, those of Drs. Austin, Doler, Chisholm and Higdon, all being referred to the board of censors.

A communication from the Secretary of the State Medical Association was read, relative to the time of paying dues, and a motion that all dues be paid before January 1st., was passed. As to the suggestion of the A. M. A. that a dimit from another state be accepted without question, we demur, believing that all such matters should be approved by our censors.

The president was authorized to appoint suitable committees to prepare for the annual banquet at the December meeting. Brookhaven was selected as the next place of meeting, the first Tuesday in December.

D. W. Jones,
Secretary.

Washington County Medical Society met in Greenville October 2nd. The changes suggested by the A. M. A. looking to uniform membership were approved, election of officers for 1913 being delayed, however, until after the meeting of state secretaries to be held in Chicago. Papers were read by Drs. C. W. Patterson of Rosedale and T. B. Lewis of Greenville.

J. J. Ferguson,
Secretary.

MISSISSIPPI MEDICAL MONTHLY.

E. F. HOWARD B.S., M.D., Editor and Publisher.

S. MYERS M.D., Business Manager.

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H. M. FOLKES M.D., Biloxi. M. H. BELL M.D., Vicksburg.

OFFICIAL ORGAN OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION AND ITS COMPONENT SOCIETIES.

SUBSCRIPTION ONE DOLLAR PER ANNUM.

The September issue of the *Journal of The Indiana State Medical Association* contains reports of officers of the Indiana organization that are in some respects remarkable and show a regard for completeness and detail that we in Mississippi would do well to emulate.

"Boiled down" to totals, the report of the Indiana councilors shows that in twelve of their thirteen districts there are 4163 eligible men, of whom 2324 are members of the Association. These 2324 members are organized into 76 societies which during 1911 held 763 meetings—some held as many as 30, one held none—before which 853 papers were read and 823 case reports presented. The average attendance, omitting the society that held no meetings, varies from 57 in a society of 294 to 3 in a society of 13. A few of the smaller societies do not give the average attendance and some do not state the number of meetings, but the figures that are given show a healthy life and interest that are exceedingly encouraging. One item is especially noteworthy: the twelve councilors report a total of 126 official visits to their charges, and we cannot but believe that this has an important bearing on the successful work done by the Association.

At the 1911 meeting of our own State Association the secretary made an informal suggestion to the Delegates that $250.00, or as much thereof as was necessary, be set aside as an expense fund to be used by the president in going about to the meetings of the various county societies in an effort to arouse greater in-

terest in medical organization. We are still of the belief that it would have been money well spent, for it is not in any way reflecting on the councilors to assert that sometimes one man succeeds where another fails, that a president working for the success of one year's administration is apt to bring more enthusiasm to his work than a councilor can have after he has been repeatedly refused or ignored, or that a man from a distant locality can in matters of this sort be frequently more effective than the home man.

A study of the councilors' expense accounts shows that our Association has spent only $195.75 on organization in the past five years. This, of course, does not represent the entire outlay, for our councilors do a large part of their work by correspondence for which none of them have made any charge, but it does represent the entire outlay of the *Association* for this purpose —a small sum for the work that has been accomplished and a pitifully small sum compared to what we should spend and will have to spend to materially better our condition. We have about reached the limit of growth on our present conservative lines and will have to wake up and get busy if we are ever to make such a showing as is done by Indiana.

A copy of the editorial touching on the possibility of the presence of negro members in northern medical associations being a stumbling block to the proposed uniform membership plan was sent to Dr. Green of Chicago, secretary of the Council on Public Health and Education, and the following letter was received in reply to it:

CHICAGO, OCTOBER 4TH. 1912.

DR. E. F. HOWARD.
Vicksburg, Miss.

DEAR DR. HOWARD:

I have your letter of the first with enclosures. Regarding the question discussed in the editorial, this question has naturally come up a number of times. Personally, I have always felt that the best way to treat it was to discuss it with perfect frankness. Such a situation as that which arose in the American Bar Association could never become possible in the American Medical Association, for the simple reason that the fundamental principles regarding membership in our organization is that each state and county organization has supreme and final jurisdiction over its own membership. Some years ago a doctor from Alabama, who was the secretary of his county society at the time, was here at the Association building and asked me about this point. I told him that the rule in the American Medical Association was that each state society decided for itself who should be eligible to membership. Some of the state societies in the north have no restriction regarding color. That is, any legally qualified physician who is a graduate of a reputable school, and whose personal character is satisfactory, *may* become a member of a county society on vote of the members. Most, if not all, of the southern states have a provision limiting

membership to white physicians. This is, of course, their right, which has never, so far as I know, been questioned.

Now regarding the matter of transfer. If any man, whether black or white, moved from a state in which he was eligible to membership to a state in which he was not eligible to membership, his membership would lapse. He would simply not be eligible to admission in the medical society in the state to which he had moved. The provisions regarding transfer are intended to apply only to those who are eligible for such transfer. I think you will agree with me that this removes any difficulty. The trouble with the Bar Association is that it is like the American Medical Association was many years ago. That is, it has a membership independent of membership in state societies, and therefore not subject to local control.

I shall hope to see you on the 23rd. and 24th. and feel sure that we will have an interesting and an enjoyable meeting.

Very truly yours,

F. R. Green.
Secretary.

Letter to The Editor.

Clarksdale, Miss., September 24th. 1912.

My Dear Mr. Editor:

The next meeting of the Clarksdale Six Counties Society will be held in the Elks Club, Clarkadsle, Wednesday, November 6th., afternoon and evening. Dr. Isadore Dyer, of New Orleans, will hold a skin clinic during the afternoon session. Come up and be with us. We will get an extra keg of beer if you promise to come.

Yours,
T. M. Dye,
Secretary.

Comment. It is easily seen why Dr. Dye is always so anxious to know the exact number who will be in attendance at the meetings in Clarksdale. He doesn't want to be obliged to share his keg with anyone. One reason for the splendid attendance at Clarksdale is perhaps also explained. County secretaries are requested to take notice.

Book Reviews.

THE PRACTICAL MEDICINE SERIES—Comprising ten volumes on the Year's Progress in Medicine and Surgery—Series 1912, Vol. IV. Gynecology. The Year Book Publishers, 40 Dearborn Street, Chicago. Price of series $10.00. Vol. IV. $1.25.

The series is published primarily for the general practitioner and covers the entire field of medicine and surgery. It is the best year book the reviewer has yet encountered.

E. F. HOWARD.

COLLECTED PAPERS BY THE STAFF OF ST. MARY'S HOSPITAL (MAYO CLINIC) FOR 1911. Octavo of 603 pages, illustrated. Philadelphia and London: W. B. Saunders Company, 1912. Cloth, $5.50 net.

The world wide reputation of the Mayo clinic is such that no introduction of its members is necessary. The volume does not lend itself readily to a critical review, being composed of various papers on as many different subjects read before different medical organizations, but there is no physician or surgeon engaged in practice who will not find valuable inspiration and advice somewhere in its pages.

E. F. HOWARD.

SURGICAL AFTER-TREATMENT—a Manual of the Conduct of Surgical Convalescence—by L. R. G. Crandon A.M., M.D., and Albert Ehrenfried A.B., M.D. Second edition thoroughly revised—with 256 original illustrations. W. B. Saunders Co., Philadelphia and London, 1912. Price $7.50.

When the operation is over, what then? What little details are to be observed, with what treatment is each separate operative procedure to be followed? Of course, when one has the advantage of years of hospital training under competent surgeons, such questions are unnecessary for the knowledge is acquired in the hard school of experience. But such experience is not possible for all men and, therefore, this work fills a most important place, taking up the patient when he leaves the operating room, and carrying him through every detail necessary to a complete convalescence. As they truly say, hospitals develop forms of treatment which becomes traditional. They may be bad, yet they are adhered to, and it seems bad that not only the surgeon inside the hospital, but the one outside should have to learn the after-treatment empirically at the patient's expense. Particularly will this book appeal to that large class of physicians who are compelled to call in a specialist to operate, and after his departure, they are left with the after-treatment of the case. This work, based on commonsense and not too rigid in its directions to allow the individual's goodsense to alter its rules, if necessary, will at such a time be a veritable tower of strength. We cordially advise our friends to possess a work that is as helpful as this.

S. MYERS.

MUSCLE SPASM AND DEGENERATION IN INTRATHORACIC INFLAMMATIONS AND LIGHT TOUCH PALPATION by F. M. Pottenger A.M., M.D., LL.D., Monrovia, Cal. C. V. Mosby Company, St. Louis. Price $2.00.

While with the enthusiasm that is natural in one who has spent some time in studying a method that appeals to him, Dr. Pottenger makes conclusions from what most of us will consider insufficient premises, his book will bear reading and will prove of interest to those who are looking for new wrinkles in diagnosis.

E. F. HOWARD.

MISSISSIPPI MEDICAL MONTHLY

VOL. XVII. DECEMBER 1912. NO. 8.

PRESIDENTIAL ADDRESS.

S. L. STEPHENSON M.D.,

MARKS.

To The Members of the Clarksdale and Six Counties Medical Society:

Gentlemen:

It is not the intention of this paper to burden the members of this meeting with a lengthy or technical dissertation.

The matter selected is a discussion of a few of the problems confronting the rank and file of the medical profession.

These problems are not so manifold as during the year past: thanks to the zeal and enthusiastic effort of this society, together with the hearty co-operation of kindred societies of this state.

By sending our own good doctors to the legislature we formulated and succeeded in passing an amendment to the old medical practice act, thereby giving the state of Mississippi as comprehensive and as dignified an act governing the practice of medicine as have our most progressive medical states.

The medical fraternity of this state has just cause for sincere congratulation upon the passage of this bill, for with it higher standards of medical education are expected, and applicants for license must submit their diplomas before the examining board before practicing within our borders, also assuring the citizens against incompetent practitioners and medical guidance; at the same time protecting the physician who has devoted years to bettering and raising the medical standards of the state.

This law carried with it the principle of reciprocity which is a boon to the men who have practiced medicine for years creditably in this state, and who desiring to change their residence must be subjected to annoying examinations even in our sister states, thereby working a useless hardship upon them.

Without doubt the most important progress in medicine during the last twenty or thirty years has been in the prevention of disease. Not only have communities awakened to the fact that by applying the principles of preventive medicine we can avoid disease and prevent its ravages, but that in so doing we benefit the people in many material ways.

But to prove to you that we are still in the embryonic stage is to recite to you the statistics of an eminent authority who states that twenty-seven per cent. of our annual deahs are of babies under five years, and of these two hundred thousand die of preventable diseases. Of this number one hundred and fifty thousand die before they are one year old.

In this country the death rate above the age of forty has increased twenty-seven per cent. since 1880. Our death rate from degenerative diseases of the heart, blood vessels and kidneys has increased one hundred per cent. since 1880. Cancer takes off seventy-five thousand, while tuberculosis takes a toll of one hundred and fifty thousand. Typhoid takes its part by slaying twenty-five thousand. This same authority claims three hundred thousand are injured more or less by typhoid ravages.

According to the rates of the National Conservative Congress, held at Indianapolis this year, the economic loss due to preventable diseases, and death, is estimated at one billion five hundred million dollars, while our fire loss is only two hundred and fifty million dollars. Yet to prevent fire loss our cities spend through the public service one dollar and sixty-five cents per capita; while to prevent life waste thirty-three cents per capita only is expended.

It is claimed by medical investigators that our people to the number of one million five hundred thousand are constantly suffering in one way or another from preventable diseases.

Of this general estimate Mississippi has its pro rata, and so one of the main purposes of our medical meetings should be to arouse public interest to the extent that our legislatures would be stimulated to appropriate larger funds each year to enables the State Board of Health to add additional measures to its present grand work of medical enlightment throughout our commonwealth.

A great work has been performed for the material welfare of this state during the last two years in the campaign of education on hygiene and sanitation by our State Board of Health.

Like all instances of great works, it took the public a

long time to awaken to the importance and significance of it when first commenced; but at the present there are signs that the people are working with eyes open to conserve human life and are adopting sanitary methods of teaching and living.

The men who have this stupendous task of educating our people to laws of hygiene and sanitation went about it with much energy and courage, and the result is the people know of hook-worm, typhoid, malaria, small pox, scarlet fever, diphtheria and other contagious and infectious diseases that yearly exact such a fearful toll of human life. Before this campaign the people refused to be bothered to any extent with this work, but now since the great demonstration given by the faithful band of health workers they are in many instances lending a helping hand.

A great obstacle in the path of medical teaching is the very low standard of the public health conscience existing in our state, and we must enlist every influence and aid possible to help our great work to better accomplishment.

To properly assist in this uplifting campaign against disease and death, we physicians must co-operate with our respective county health officers in indicting and eliminating disease from our midst.

To show to the citizens of our state that the work undertaken by our board of health has borne much fruit, will be only to cite to them these figures, namely, that during the past year the state board of health field workers have made microscopical examinations of forty-five thousand persons between the ages of six and sixteen years to ascertain the existence or non-existence of the hook-worm. In this work the name of each individual examined and treated was recorded, so there can be no gainsaying the fact.

Of the forty-five thousand persons examined it has found that sixty-five per cent. of the number were suffering from hook-worm and were unfit for any form of work. So it is incumbent upon us to form an active campaign of education on general health topics, especially the eradication of the hook-worm.

That we are too prone to skimp in our examination of the patient is manifest. That we place too much dependence upon subjective and too little upon objective symptoms is patent.

According to physical diagnosis, in the subjective examinations we get only what is perceived by the affected individual, but by the objective it is possible for us to denote many morbid

and unrecognized diseases; such as abnormal conformations of the chest, displacements of the apex beat of the heart, changes in the structure of the skin, neoplasms, sinuses, malformations, enlarged glands, concealed ulcers, venereal complications, tumors, hernias and what not may be discovered. So let's give each individual patient the benefit of a diagnosis, a differential diagnosis, and a correct treatment of the disease in particular.

,It is with regret that I call your attention to the continued contest of some insurance companies with the physicians of our state.

This matter has been discussed *pro* and *con* before our meetings for many sessions, and yet we are still, through the lack of medical entirety and principle, compelled in combatting the evil.

At one of our semi-annual meetings a resolution was adopted, to which I think all members of this society pledged their support, to the end that they would refuse to make and examination for old-line insurance companies for less than a fee of five dollars. To what extent these pledges have been kept, I believe I could safely attest that in the great majority of cases they have, but in a few the guards have been dropped and the enemy is still with us.

How a member of the medical profession of this or any state will make these examinations without proper compensation other than private hope of personal gain is beyond me. To my mind, examinations for fraternal order insurance companies for less than the fee of five dollars is emphatically wrong.

These companies under the guise of fraternalism demand the same exhaustive and scientific work from us as the old liners. And while we are a prey to their shrewdness they gather in their thousands and wonder at our stupidity.

Gentlemen, I condemn this as I do the unfortunate condition which confronts the medical profession of this country as a whole in the character of fee-splitting, contract practice system, rebating and where for a certain price an unknown amount of labor is promised and where the low bidder gets the plum. Every physician should, for the honor of his profession and his own self-esteem, refrain from such a pact.

In conclusion I wish to state that we are part and parcel of the great profession of medicine and surgery, a profession which has within its ranks more self-sacrificing, more unselfish and more sympathetic men than has any profession. To re-

peat in the splendid language of a distinguished newspaper editor:

"In aptitude of mental equipment, in learning, in strength of character, in loftiness of ethical standards and in unselfish devotion to humanity, the physician who lives up to the ideals of his profession leads them all."

It is gratifying to see such enthusiasm and willingness of co-operation on the part of the members of this society, and by such co-operation as this we will establish our profession in great honor and respect in the eyes of the people which it so rightly deserves.

As the month-piece at this meting for this society, it is my duty to point with pride and delight to our visiting brethren and we trust that they will in the future, as in the past, lend us their scientific presence, their intelligence and their good fellowship.

*TREATMENT OF TYPHOID FEVER WITH TYPHO-BACTERIN.

C. W. PATTERSON M.D.,

ROSEDALE.

Having used typho-bacterin in the treatment of nine cases of typhoid fever during the past year, I would like to say a few words in its favor. I will begin by mentioning the methods used by me in diagnosing these cases that I may remove all doubt in your minds as to their having some disease other than typhoid.

In five of the cases, I had blood tests made before giving the bacterin, and received positive reports, in the remaining four I based my diagnosis on the gradual onset, appearance of the tongue, tenderness over the abdomen, nervousness, and by the quinine test, giving fifteen grains daily hypodermatically for six days; having excluded all other diseases in the beginning except malaria and typhoid, I believe that I was justified in my diagnosis.

I think it would be unjust to burden you with each case separately, so will only speak of the treatment of all nine cases in a way to better impress upon you the proper method of using typho-bacterin if you wish to have the required results. To begin with be sure to give large enough doses or do not use it at all. I always begin with five hundred million

* Read before the Washington County Medical Society.

killed bacteria and on the second day give one thousand million, continuing the latter dose every two days, until the temperature of the patient is normal. Of course the patient must be watched and all complications given their proper treatment. Two of my patients I gave the typho-bacterin by the tenth day, and their temperatures were normal by the fifteenth, while with those who had fever from fourteen to twenty-six days before receiving the treatment, it took longer to reduce their temperatures to normal; yet each case showed improvement from the first injection; for example, I had a negro preacher under treatment, and although his blood showed a positive Widal, I never gave the typho-bacterin until the twenty-sixth day, when he developed pneumonia, with a temperature of 105½° F., and pulse 150. Upon raising his head about three inches to give him a dose of medicine he fainted, so having a tube of one billion, five hundred million, killed bacteria with me, I gave him the full amount with the results that on the next morning, I found his temperature 100° F., pulse 108 and lungs much improved, he having only a small amount of blood in his sputum. In about three or four days more his temperature was normal. Another case was a negro woman brought to me from White River, Arkansas, after having had fever for eighteen days, so I gave quinine hypodermatically until I could get a report from her blood, and upon receiving a report of positive reaction, I gave her five hundred million killed bacteria, which caused her temperature to drop to 103° F., being 105° F. when I gave the treatment. In two days I gave the second dose with another drop of temperature to 100° F. and in two more days, I gave the third dose, and found her temperature normal in two days after this dose. Now, I merely mentioned this case that I might speak of her three-months-old baby; you know that negroes are better about not allowing babies to nurse a mother with fever than the ordinary white woman, anyway this baby was taken away from the breast until one day while the baby was on the bed with the mother she nursed it, and eight days from that time the child developed fever with no bowel trouble, until I gave calomel in eighth grain doses, when she developed a diarrhœa which was very hard to check, but then the temperature continued to rise higher each day, so I gave nine grains of quinine hypodermatically every day for three days, and seeing no improvement I gave three hundred million killed bacteria, and in two days five hundred million more, resulting in a normal temperatnre on the third day after the last dose.

Could it have been possible for a baby three months old to have typhoid fever? Anyway, if it wasn't typhoid; what other disease would have reacted to the typho-bacterin?

Now you can see that I have used typho-bacterin in the extremely young, the very weak, and the old, with nothing except good effects, while with cases I treated before hearing of typho-bacterin the fever lasted anywhere from thirty to sixty days and would then be followed by some complication in a few instances. For example; a ten-year-old boy developed purpura hemorrhagica about ten days after his temperature was normal, so having just used my first typho-bacterin, I thought I would try it on him and gave a dose of five hundred million killed bacteria and also five drops of adrenalin chloride (1 to 1000) every four hours. Whether the typho-bacterin benefitted or not, I will only say that I couldn't see where it did any harm, as the boy recovered in a few days, so I felt satisfied with the results and would use the same treatment should I have another case following typhoid.

There is one thing I am sure of about typho-bacterin, and that is I have never yet seen any ill-effects from its use, so knowing of no other treatment, I, for one, intend using it until something better is discovered.

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*MALPOSITION OR LOSS OF TEETH: AFFECT ON MASTICATION.

R. W. GASTON D.D.S.,

GULFPORT.

In presenting a paper before a body of physicians I was rather at a loss to know what subject to select and also how to present it so that it would be of any interest, as I realize it is the case—at least among us of the dental profession—that we are so engrossed in the study of subjects bearing directly on our work that it is hard for us to interest ourselves very deeply in anything aside from this; and so I have selected a subject which, I think, bears very directly upon the work of the physician, that is the mal-position or loss of teeth as it affects mastication.

The great tendency of the present time in dealing with any abnormal condition of the human body is toward prevention, rather than cure, of the condition.

*Read before the Harrison County Medical Society.

If we can cure or correct the condition after it has been established, we are doing a great deal; but if we can prevent the condition becoming established, we are doing a great deal more.

When we come to the treatment of any abnormal condition we first look for the cause of the trouble, and if we can remove this, we have progressed a long way toward a cure. Where we find those cases of mal-occlusion of the teeth, that are so often caused by the extraction of one or more of the first permanent molars with its resultant evil effects, it should make us stop and consider if there is not some other way of relieving the trouble than by the loss of one of these most important teeth; yes, I say most important, for doubtless the first permanent molars are the most important teeth in the mouth and yet they are the ones most frequently lost, because erupting at about six years of age, they have a period in the child's life to go through with that is very prone to cause decay.

Let us consider the results of the loss of the lower first molars, for instance; well, we may say the space will close up after a while, so what is the difference? It would probably be better if the space did not close up, for, as we know, each tooth of the lower jaw is locked in occlusion with two opposing teeth of the upper jaw, the cusps of one tooth fitting in between those of the others, thus having the effect of a mortar and pestle in the grinding of food; but when a molar is lost, the neighboring teeth, drifting toward the space caused by the loss of the tooth, lose their relative position in the dental arch, and instead of striking between the cusps of opposing teeth, strike on the points of the cusps, which you will realize would have more the same grinding effect as two pestles grinding together, than the mortar and pestle as we had before.

When a tooth has moved from its proper place in the arch and occludes on the points of the cusps of the opposing tooth instead of between them, its grinding efficiency has been reduced at least sixty per cent. as you can readily see by comparing the model of teeth in normal occlusion and the one in which the occlusion has been deranged as mentioned above.

Consider what will be the effect upon the digestion if the patient has lost, say, one lower molar on each side and the efficiency of his mastication has been reduced sixty per cent. We all admit that the thorough mastication of food is one of the prime essentials in its digestion. The same thing holds

true in regard to teeth that are in mal-position. The mastication is crippled just to the extent of mal-position of the teeth. They, being crowded, are imperfectly cleaned, they are improperly exercised, and in addition to the loss suffered from imperfect mastication of food, we have a congested and inflamed condition of the entire mucous membrance of the mouth caused by the retention of food particles and lack of proper exercise of the surrounding tissues.

In the foregoing I have dealt mainly with the conditions inside the mouth, and now let us consider for a few minutes the effect on the general appearance of mouth and profile of the face of a patient suffering with mal-occlusion of the teeth.

Dr. Edward H. Angle has divided the cases of mal-occlusion into three classes, and we will only consider one division, Class II, as it is in this class that we have the greatest derangement of the facial lines and of the normal profile of the face.

This class consists of those cases in which the upper teeth protrude far beyond the lower, the chin is receded and the entire mouth and lower part of the nose is very much narrowed, giving, because of the recession of the chin, the face a weak appearance.

These cases are generally caused by mouth-breathing, the patient being unable to breathe through the nose because some obstruction, such as adenoids, etc., keeps the mouth partly open the greater part of the time, and especially at night, hence the opposing jaws lose the support caused by locking the teeth in normal occlusion, and, the buccal muscles being tense, we have a gradual narrowing of the jaws, caused by this continued side pressure forcing the upper teeth forward and allowing the chin to recede because of the action of the muscles of the lower jaw.

These cases are very interesting, both to the general practitioner as well as the dentist, because the welfare of the tissues of the nose and throat is as much involved as the teeth themselves, to say nothing of the marred appearance of the face itself.

In the treatment of these cases, of course, the first step is toward the removal of the cause; the nose and throat should be looked after and gotten in a healthy condition, removing any obstruction that may be necessary in order for the patient to have normal breathing through the nose, and not have to breathe through the mouth, as it is almost impossible to perma-

nently correct a case of this kind as long as the patient has to breathe through the mouth.

After these conditions have been relieved, the mal-position of the teeth should be corrected, which is done by the application of appliances to widen the dental arch, move the protruding upper teeth backward and bring the receding chin and lower teeth, together with the normal width of the jaws and nasal chamber, which you can readily see increases the breathing capacity a great deal, adding to the general health and welfare of the tissues of the nose and throat, together with those of the mouth.

Now I say, in conclusion, when we find a derangement of the digestive organs, let us look to the condition of the mouth, whether there be any loss of efficiency in mastication either through decayed or lost teeth or through a derangement of their normal position in the dental arch, as one is as important as the other.

*EARLY DIAGNOSIS AND TREATMENT OF APPENDICITIS.

T. K. MAGEE M.D.,

FERNWOOD.

Since this paper will deal only with diagnosis and treatment of appendicitis with some reference to differential diagnosis, I deem it would be superfluous to refer to the anatomy of this organ only in the event that it should become necessary to emphasize some point of diagnosis.

We have heard so much and such various statements about some man's special symptom or point in the diagnosis of this trouble that as arule we are at sea to which to accept in making our decision when we are in doubt as to the exact nature of the tronble that we are called on to distinguish. Then too appendicitis comes in such varying degrees of intensity and the situation of the organ is so variable and uncertain (if we are to take the reports of operations for it) that we are likely to overlook our hand and prononnce a genuine though mild case something else other than what it really is.

Some claim that this organ is sometimes fonnd in the region of the kidney, sometimes on the left side and in the umbilical region and I have seen one report where a patient was operated on for this tronble and the organ was entirely

*Read before the Tri-County Medical Society

lacking. Inflammatory conditions of the coecum in parts remote from the appendix can, and do, not infrequently, give a train of symptoms that are likely to lead to confusion and doubt. Typhilitis being an inflammatory condition of the body of the coecum is early confused with it, in which if the appendix is invaded at all it is secondary by a continuation of the inflammation along the mucus membrane. Pneumonia, when situated in the right lower lobe has been mistaken for the malady and I have no doubt that many cases are mistaken for acute indigestion and colic.

For the purpose of this paper this trouble may be classed: (1) acute catarrhal, a form in which the organ is infiltrated and congested and occurs in first and primary attacks; (2) chronic catarrhal or a condition that arises after repeated and various attacks be they severe or of the mildest type; (3) purulent appendicitis is advanced from the acute catarrhal form with the addition of walled abscesses, necrosis, and all the symptoms attended with pus in any other organ.

The diagnosis of this stage is not as a rule attended with any unusual trouble as we have every indication of suppuration, a tumor of varying dimensions and outline lying in the right iliac fossa, pain especially on moving the right leg and extreme soreness and tenderness over the site of the organ.

The second form is usually easy of recognition. There is a history of repeated attacks, pain, tenderness, flexion of the legs and thoracic breathing so as to give relief to the tense and rigid abdominal muscles and if there is any reliability to be attached to McBurney's point we will get tenderness on pressure midway between the unbilicus and the crest of the ileum.

The symptomology of the acute catarrhal condition is the same practically as that of the second named form without a history of repeated attacks. It is usually not attended with prodromal symptoms; the patient having been previously well, is seized without warning with colicky pains varying in intensity with the amount of involvement, in the lower part of the abdomen, slight nervous disturbances occur, no fullness can be detected and there is no recognizable tumor present. The temperature and pulse are accelerated in proportion to the severity of the attack. There may be nausea and vomiting. Constipation is the rule. These symptoms may be more marked when the serous layer of the organ becomes involved.

The symptoms are sometimes so vague and inconsiderable

that the anxiety of the patient and his friends is not aroused and the doctor is not called until perforation has taken place and there is grave danger of a serious peritonitis supervening.

Thus it is to be seen that pain is the paramount symptom and this taken in connection with its character and location, with the previous history we ought to be able to distinguish any case of moderate severity at a first visit or to say the least of it within twenty-four hours. The fact is that any pain in the right iliac fossa naturally suggests to us the condition with which we are likely to have to deal and we would most assuredly make a correct diagnosis even though it had to be done by elimination.

In colic and acute indigestion the short duration of the pain will materially aid in clearing the diagnosis while in typhlitis we usually have diarrhœa instead of constipation; in pneumonia the lung symptoms ought to be so pronounced in twenty-four hours as to enable us not to go wrong.

As to the matter of treatment the profession is hopelessly divided, though not so much as in former years. There are those who still adhere rigorously to the idea that all primary cases can be and are cured by medication and poultices and often we see some article exploiting some special scheme for the treatment and cure of this disease. Some adhere to cold applications, while another lot will advise only hot applications. Some advise the use of an enema, either plain or medicated, as a means of emptying the bowels and others advise salts, castor oil, calomel, or some other purgative. One thing that they all agree on, and that is an opiate in some form for the relief of pain when it gets to the point of intolerability. It has been my experience that all primary or acute cases will recover from the first and many subequent attacks with almost any kind of medication; but there will finally come a time when to get relief and to save life the knife will be the means. It would be useless to discuss the mode of procedure in these operations. All who advocate or who are from necessity by the gravity of their case driven to the operative method of treatment, are agreed that the complete removal of the appendix in all cases where suppuration has not been established is the proper thing to do and almost every man of note has his special pet way of doing the operation and tying and hiding the stump; he even has his favorite antiseptic for touching the stump with and each one can give you an array of statistics to prove that his is the best. They are all good and it

is only a matter of personal preference to the operation. In cases that have advanced to the stage of suppuration and abscesses there is still some difference of opinion as to whether it is best to always remove the appendix which would necessitate the breaking up of many adhesions or not. The time selected for the operation is also a mooted question, some insisting on the operation when the diagnosis has been definitely settled upon and others preferring to wait for the acute symptoms to subside and do the operation during the quiescent period while there is no inflammatory condition to interfere.

Operations are clearly indicated in two conditions; first as soon as there is positive evidence of an abscess and second when the symptoms point to perforation into the peritoneal cavity. In such cases an immediate operation is all that offers any chance of recovery and should invariably be done with as little delay as possible. In my opinion the operation can be done at almost any time and the sooner it is done the quicker will be the relief and recovery of your patient. The plan of local applications and purgatives and waiting for developments is fraught with danger. Then, too, the opinions or desires of the patient have to be reckoned with, many of them persistently refusing to be operated on simply from the fear of the knife, never stopping to reason that a big cavity filled with nasty pus is all the time threatening to rupture and evacuate itself into the peritoneal cavity with only one result. By plain and judicious reasoning this can usually be overcome and you can get their consent, but usually not until the abscess has formed and the grim reaper is near at hand.

I don't think I have, and did not propose to advance any new ideas in this paper, but hope to provoke a discussion and thereby elicit for myself at least some valuable information.

*APOMORPHINE

C. F. CARROLL M.D.,
BILOXI.

Apomorphine is derived from morphine or codeine by the action of a strong acid or zinc chloride.

The form most commonly used is the hydrochloride, which occurs in minute white crystals, odorless, of bitter taste, soluble in about forty-five parts of water, sparingly soluble in

*Read before the Harrison County Medical Society.

alcohol and not at all soluble in chloroform or ether, and is decomposed by boiling.

The dose is variable, according to indications: as an expectorant one-fortieth to one-twentieth grain, as an emetic one-fifteenth to one-eight grain. Solutions of this product should always be freshly prepared as they rapidly deteriorate by keeping.

Apomorphine in a dose of one-tenth grain, hypodermically administered, is one of the surest emetics we possess. It acts directly upon the vomiting centre and is the quickest and least irritating of all emetics, acting as a rule within from three to five minutes, although I have seen instances occasionally where its action was slower.

The nausea, while severe, is of short duration and is followed immediately by a period of complete muscular relaxation during which the patient, if let alone, will usually fall into a restful sleep lasting from one to three or six hours, from which he awakens feeling none the worse for the experience.

Apomorphine hydrochloride, when fresh, is of a grayish-white color which soon changes to green or black upon exposure to light and air. Some claim that the drug when green or blackish in color is physiologically inert and even dangerous to use. Personally I have found very little difference as I have repeatedly used tablets almost black in color and obtained practically the same results as when using the fresher preparation. I have noticed that the darker tablets are harder to dissolve.

As to dosage, Potter gives the hypodermic emetic dose from one-fifteenth to one-eighth grain; I find that as a rule one-tenth grain will be followed in the majority of instances by prompt emesis. The dose to produce reaxation and sleep is given as one-twelfth grain. I have given this dose in several instances and found that it acted as an emetic as quickly as one-tenth, while at other times it would simply produce relaxation with sometimes slight nausea which would soon pass to be followed by restful sleep.

The drug, like many others acts with more vigor in some individuals than others and the dose must be selected to fit the individual case.

I recall a case of acute alcoholism in which one-tenth grain dose produced symptoms of collapse, cold surface, profuse perspiration, unconsciousness and absence of radial pulse. Physiological action: the symptoms following administration of one-

tenth grain dose have been noted as follows: usually within four minutes the patient became restless, turning from side to side, moving the extremities, pulse quickens, pupils dilate slowly, the face is flushed, respiration is increased and usually perspiration is evident. This condition is quickly followed by profuse vomiting, which lasts from a few minutes to half an hour, recurring at intervals of from five to ten minutes within the half hour. After the vomiting has subsided a reaction occurs, the pupils, if noted, will be found dilated, face pallid and drawn. I have noticed that at this period the patient will ofttimes begin yawning which is usually a sign of cessation of the nausea and vomiting; sleep follows shortly and upon awakening all effects have passed off.

The drug seems first to excite the cerebral centres as patients will frequently become highly excited; this is shortly followed by depression.

The peripheral arteries become prominent and tense, indicating increased arterial tension due to increased heart's action. For this reason one should be extremely careful in giving the emetic dose to the aged or sclerotic.

Therapeutics: as an emetic, apomorphine is without a doubt the most reliable and especially so when time is valuable as in cases of poisoning.

A case where two grains of strychnine was taken by mistake, when seen twenty minutes after ingestion, showed symptoms of strychnin poisoning, twitching of muscles, difficulty in swallowing, etc., one-tenth grain apormorphine given hypodermically, produced immediate and profuse vomiting, after which physiological antagonistics were used to counteract the amount of poison already absorbed.

As an expectorant, dosage from one-eightieth to one-twentieth grain ofttimes affords great relief in bronchitis and asthma.

As a hypnotic it is found to be of exceptional value in acute alcoholism and in some cases of insomnia.

As the action of apomorphine usually lasts from two to three hours, bromide of chloral or some of the recognized hypnotics, if administered at the expiration of this time will usually insure a more protracted hypnosis.

In croup, when evacuation of the stomach is desirable, the drug in proper dose acts promptly and is followed by happy results. Cardiac depression should be carefully watched for and combatted by suitable heart stimulants.

In cases of indigestion and violent gastralgia, apomorphine is efficient. From the fact that its action is due to centre stimulation and not by irritation of the mucous membrane, it is the preferable remedy where emesis is desired, over those that depend upon irritation of the mucous membrane for their action.

In hysterical crises, apomorphine has proven to be a sovereign remedy; one-tenth grain hypodermically administered, will invariably abort or cut short hysterical convulsions and in a number of instances where patient was apparently unconscious (?), a condition of complete muscular rigidity present and all evidence of complete insensibility quite evident, a one-tenth grain dose of apormorphine instilled new life into the patient and brought about almost immediate recovery. In one instance three such treatments produce a cure that has lasted over two years.

The drug is especially valuable to the extent of allowing the physician to leave the house within from fifteen to thirty minutes, having performed a miracle and leaving behind him a much surprised patient and a grateful family, cutting short the long seances in which all the neighbors participate, with the doctor, occupying the center of the stage, dodging the numerous queries: "What shall we do next, Doctor?"

Personals.

Dr. S. W. Glass of Dublin, president of the Mississippi State Medical Association, has moved to Lyon.

Dr. S. E. Frierson of Lyon has left for New Orleans where he will spend a year in post-graduate work at Touro Infirmary.

The case is reported of a girl of eighteen who, having previously suffered from gastric symptoms, evinced jaundice twenty-four hours after seeing a woman knocked down by a tram car. This recalls Dr. Oliver Wendell Holmes' observation:

"I remember a young wife who had to part with her husband for a time. She did not write a mournful peon: indeed she was a silent person and hardly said a word about it. But she quietly turned a deep orange color with jaundice." Such instances, though rare, evidence an interesting phase of psychic reaction upon the human economy.—*American Practitioner.*

MISSISSIPPI MEDICAL MONTHLY.

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OFFICIAL ORGAN OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION AND ITS COMPONENT SOCIETIES.

SUBSCRIPTION ONE DOLLAR PER ANNUM.

The meeting of state secretaries held in Chicago Oct. 23rd. and 24th. was an eye-opener to Mississippi's representative and convinced him more than ever before that organized medicine is one of the biggest things in this country, and that when the doctors really wake up to what they can do it will be the means of getting them anything they may care to ask from the national government. It was, too, just about the most harmonious meeting the writer has ever atended, despite the fact that every section of the country was represented, and while the discussions brought out the fact that different states use widely different methods of administration, that feature only added to the interest of the occasion.

The questions up for discussion related to the dates of the fiscal year, automatic expiration of membership at the end of each year, the date at which reports from county secretaries should be due, the pro-rating of dues of members joining after the first of the year, the advisability of an entrance fee, the advisability of uniform stationery in the state secretaries' offices, the chartering of the state associations by the A. M. A., and the advisability of adopting a plan of uniform transfer of membership between state associations.

The two questions that most interest us in Mississippi come last, since the recommendations on the other questions conform to our own ideas: the House of Delegates of the A. M. A. has been asked to consider the advisability of chartering the state associations and the uniform transfer proposition was tabled.

This means that our delgates to the A. M. A. must go on the job and stay there until it is over. Were the matter to be entirely left in the hands of the secretaries, judging from the men present in Chicago, it would be a matter of no moment, for nothing that might raise uncomfortable discussion would be done, but as the matter is to go to another body our men should see that the work is done in a manner to which we can subscribe. We say judging from the men present in Chicago: one of the most amusing as well as interesting things in the whole meeting was to hear the secretary of the Pennsylvania State Medical Association gravely advocating the doctrine of states's rights. With that sort of sentiment abroad the men living in the black belt can at least close one eye for a nap without being apprehensive of an attempt to break the "color line" by their northern brethren. A complete account of the meetting will be found in the A. M. A. *Journal*, Nov. 2nd., page 1642.

Opening our first of the month mail, a heavy job for 'tis then that the editor's desk is piled high, we came in due course to a plain envelope postmarked New York. Reassured, for we haven't bought anything from either Rebman or Appleton in the last thirty days, we opened it and found the following, which was mimeographed, all but the heading:

DR. E. F. HOWARD, Ed.,
Mississippi Medical Monthly,
714 S. Cherry,
Vicksburg, Mississippi.

I beg to direct your attention to an article from my pen on Infant Feeding which appeared in the October issue of Pediatrics, and would appreciate any editorial reference which you might make, and append below a short notelet for your convenience which you may change or amend to suit your editorial judgment.

I am also enclosing you a short abstract of this paper and would appreciate it, if you can give it space in the next issue of your most estimable journal, and whenever I can return the courtesy I am yours to command.

Very truly and sincerely yours,
W. E. FITCH M.D.
Editor of Pediatrics.

The editorial "notelet" was to the effect that the paper had appeared in the place indicated in the letter and that "copies can doubtless be had of the author." You bet they can; lots of 'em; gratis!

The predigested, prepared abstract states that "First Lieut. W. E. Fitch of the Medical Reserve Corps, U. S. A., has

written a most practical paper upon the subject of Modified Cow's Milk As A Substitute Food In Infant Feeding." Ye Gods! What a plum! What in the name of all the gods of war has the Medical Reserve Corps, U. S. A., to do with infant feeding? Or is it Dr. Fitch's job to care for the children of the (*w*)*hors de combat?*

Of course it's all advertising, but isn't it crude and bald? But we will puff it for him. It's a good article. We haven't read it, but it's good. Dr. Fitch says so, and he ought to know for he wrote it. At least he says he wrote it and he says it's good. As an "officer and a gentleman" he must tell the truth, therefore it's good.—*Q. E. D.*

But to think of this mimeographed letter and cold-storage editorial and abstract going the round of the small journals. Watch some them bite!

Thank you, Dr. Fitch, you have at least helped us when the copy boy was pressing, and primary wrath is swallowed up in admiration of your advertising methods. They'd be fine if you could put them across.

Society Proceedings.

The union of the medical societies in Hinds and Rankin, authorized by the last House of Delegates, will take place officially January 1st. 1913. Dr. B. L. Culley, Jackson, is president and Dr. E. H. Galloway, Jackson, secretary of the new organization.

DeSoto County Medical Society has elected officers for 1913 as follows: A. J. Weissinger, Hernando, president; L. H. Breard, Eudora, vice-president; J. M. Wright, Lake Cormorant, secretary-treasurer; A. L. Emerson, Hernando, delegate.

Clarksdale and Six-Counties Medical Society met in the Elks' Club, Clarksdale, Wednesday, November 6th., afternoon and evening, with seventy physicians in attendance, Dr. S. L. Stephenson, of Marks, presiding. Thirteen highly interesting and helpful papers were read and thoroughly discussed, but probably the most interesting feature of the meeting was a skin clinic of eight or ten patients held at the afternoon session by Dr. Isadore Dyer, of New Orleans. The following was the program in full:

"What Shall We Write?" H. C. Buck, Friars Point; "The Evil (?) Of Fee Splitting," E. L. Robertson, Belzoni; Skin Clinic, Isadore Dyer, New Orleans, La.; "Fever," J. W. Gray, Clarksdale; "Noma," T. F. Clay, Tutwiler; "Gonorrhœa," E. R. McLean, Cleveland; "Physiological Effects Of Different Purgatives," S. W. Glass, Lyon; "The Hypodermic Administration Of Quinine: Its Indications And Contraindications," W. B. Harrison, Mattson; "Cause And Prevention Of Typhoid Fever From A Public Health Viewpoint," J. T. Longino, Jonestown; President's Address, S. L. Stephenson, Marks; "Common Errors In Prescription Writing," J. C. Noah, Clarksdale; "Cholecystoduodenostomy For Chronic Pancreatitis," John Darrington, Yazoo City; "Chorio-Epithelioma And Malignant Diseases Of The Body Of The Uterus," F. D. Smythe, Memphis, Tenn.

A new constitution and by-laws were adopted in keeping with the "progressive" spirit of the times, after which the following officers were elected for 1913: President, J. A. Davis, Dockery; Vice-President, Bolivar County, J. E. Adams; Coahoma County, L. E. Pierce; Quitman County, Q. A. Davis; Sunflower County, J. W. Lucas; Tallahatchie County, W. A. Prince; Tunica County, G. M. Shaw. The old Secretary-Treasurer was re-elected. H. C. Buck, Friars Point, was re-elected Censor.

T. M. Dye.

Book Reviews.

PHYSICIAN'S VISITING LIST 1913. P. Blakiston's Son & Co., 1012 Walnut street, Philadelphia. Price $1.25.

To the general practitioner a visiting list of some sort is practically an essential and Blakiston's is one of the most satisfactory as its existence for sixty-two years amply certifies.

E. F. HOWARD.

INTERNATIONAL CLINICS. A Quarterly Of Illustrated Clinical Lectures And Especially Prepared Original Articles. Vol. III, Series 21. J. B. Lippincott Company, Philadelphia. Price $2.00.

Those who are fond of theorizing will enjoy Professor Ciesielski's article on sex-determination, an interesting translation of which forms the leading feature of this number. S. Solis-Cohen, Bevan, Deaver and Dannreuther are among the others contributing and the general character of the papers comes well up to the high standard set by this popular quarterly.

E. F. HOWARD.

MISSISSIPPI MEDICAL MONTHLY

VOL. XVII. JANUARY 1913. NO. 9.

*THE EVIL (?) OF FEE SPLITTING.

E. L. ROBERTSON M.D.,
BELZONA.

I have read with pleasure in some of the recent editions of our journals, especially the *Memphis Medical Monthly,* the articles on this question. As this has long been a mooted question with the profession I am glad the "ball" has started rolling and hope to see it continue to roll until it is thoroughly thrashed out and permanently decided.

I have tried always to live and practice an ethical life among my "Bretheren," but have often been puzzled to know just what was right.

I have been in the practice long enough to see and compare the commercialism that I find each year more and more among us. This is a regretable fact, yet where is the cure?

As long as there is the present increase in our number of doctors, surgeons, and every walk of the profession that we have today, I fear there is no cure.

I think the foundation of this and almost all other questions that are dividing our ranks comes from commercialism; our insurance laws in Mississippi for instance, which we have never been able to enforce and I fear never will.

The only cure I see for these and other questions is to continue to raise the standard of medicine, thereby making it harder to get in, keeping those from our ranks who enter it purely from a monetary standpoint.

But back to the original question.

There must as to all questions be two sides to this one. I have never had the temerity to ask the splitting of fees, though have carried a great many patients to the specialists; yet I must say that in some cases I think it nothing but right.

For instance, I or any other general practitioner will come across a case that needs an operation for a permanent cure. It may be that we can treat this case and get them up and

*Read before the Clarksdale and Six Counties Medical Society.

about but cannot give permanent results. After many hours in work and persuading we finally get the patient to agree to go to a specialist. In many and many of these cases they are poor or in moderate circumstances and have to exert every means to get up the money for the operation, for none of us feel like taking them there without the money as we know our "Specialist Friend's" pocket is "always empty," and it is cash over the table; for which we cannot blame him, but only sit back and wish we could do the same thing instead of waiting until they gin, which often never happens.

Now the family doctor has treated this case perhaps for several weeks, prepared it for the operation, and in almost all cases they insist that he go along to either help in the operation or stand by and hold their hand as they slip off into that land of anesthesia from which they fear they will never return without your help, thereby taking the doctor from his other work in which he could be trying to eke out an existence.

The operation is performed in from twenty to sixty minutes, the patient placed in a sanitarium for two or perhaps three weeks for which he has to pay from seven dollars to fifteen dollars per week, where he can be closely watched by the specialist. He is then returned to the old tired horse (family doctor) to be treated for two or three weeks to so many months.

Now for this work the specialist gets from one to several hundred dollars according to what the fellow can raise, and in many cases he has mortgaged his little home, stock or crop, or as in some cases the doctor has loaned him the money to pay this fee if he be so fortunate to have it, which is seldom, and for its return as well as his small fee he has to wait for that proverbial ginning which the boll weevil often beats him to.

Now I leave it to all fair-minded doctors who has had the hardest work in this case?

If the specialists' prices were down to a par as to the actual work and time taken with general practice, or if we could raise our fees up to that of the specialist, you would not hear so much of this fee splitting. But when the general practitioner knows that the specialist has gotten everything there can possibly be gotten out of the case, is it not natural for him to feel that for his work and being the instrument of enabling this specialist to make his fees, that he should have a division?

From the standpoint of the specialist I can well see their eleventh commandment: thou shall grab all in sight and hold on tight.

If the specialist had to depend on just such cases as he could attract himself without coming through the general practitioners how many do you think would aspire to a specialty?

Back to commercialism. If there be commercialism in fee splitting, on which side does it come; on the general practitioner who works from two weeks to so many months and at best gets a nominal fee, perhaps enough to pay for the dressings he uses on these cases after the specialist has sent them back to him, and his time away from home, or the specialist who works for a few minutes and takes all in sight or at least all he can get?

Do you not think that we of the country are due at least a "stay in?" This question has been discussed mostly from the side of the specialist who decry it *in toto*.

I would not have you infer that I am in favor of a general habit in this line, for there are cases, as those only referred to the specialist by the general practitioner in which he has had no work or trouble, or the patient is able to stand the "gaff" from both sides, in which there should be no division.

If you specialists do not want to divide the "pot," find out what the patient can stand from the doctor who brings him to you, and I think you can trust them, and leave a few flakes of cream on the "Bluejohn."

*PRESCRIPTION WRITING.

J. C. NOAH M.D.,
CLARKSDALE.

The prescriber can recognize but one boss or master, and that one is his patient. It is his aim to give the patient such medicine as will cure the disease or relieve the symptoms. After you have decided on the drugs for his particular need it is your duty to have them prepared in the most palatable form. The patient demands or rather prefers a medicine that appeals to the eye, the taste and the purse.

Insofar as possible all liquid prescriptions should be clear, if not then filtered, except of course the insoluble drugs which should be dispensed with a shake label.

Any medicine with a color is more pleasing to the eye and has a better effect especially on the negro or more ignorant class as many of you can testify. Tincture Cudbear or Elixir Lactated Pepsin will give a nice red color to alcoholic prepara-

*Read before the Clarksdale and Six Counties Medical Society

tions, while Carmine may be used for aqueous solutions. If a powder, we might use Aromatic Powder for both the odor, taste and color. In oily liquids alkanet makes a good coloring.

For improving the taste we have Fluid Extract of Licorice, the syrups of Tolu, Lemon and Orange and Aromatic Elixir; also the aromatic waters as rose, peppermint or cinnamon.

As a rule we find that men like bitter or acid flavors, while women and children want the sweets.

It seems a shame that the profession prescribes so many pharmaceuticals, when a prescription could be written that would most of the time fill the need better and cost the patient much less.

Let us pass from pharmaceutical elegance to the cause of real errors in prescription writing, that is the incompatibilities. As we know there are three classes, therapeutical, pharmaceutical and chemical.

Of the therapeutical we have very little to say. Unless we know the doctor has absentmindedly prescribed a dangerous dose we pass it up.

Pharmaceutical or physical incompatibilities are chiefly cases of insolubility, as when a body which should be administered in solution is insoluble in the combined ingredients of the mixture or when a body already dissolved is thrown out of solution by admixture with other bodies. The most common illustrations of physical incompatibilities we have to deal with are the mixture of alcoholic tinctures and fluid extracts with aqueous fluids, the dissolved drug principles being thrown out of solution and of mucilaginous bodies with strong alcoholic solutions, the mucilaginous principle being thrown as a hard stringy mass. There are three general methods of preventing pharmaceutical incompatibilities: by alterations in the solvents used; by a change in the bulk of the mixture whereby the alcoholic percentage is kept within certain limits; by emulsifying or suspending the troublesome bodies with gums or syrups.

None of these the pharmacist dare supply without first consulting the doctor.

Under chemical incompatibilities are the most important of all, as new and dangerous compounds may be formed by the combination. Alkaloids are the most easily effected in combination and as they are the most potent drugs, many of them being violent poisons, it is well to remember their incompatibilities. They are precipitated by the alkalies, iodine and the iodides, bromine and the bromides, tannic acid or other astring-

ents. We may prevent precipitation in some instances by using a menstruum of from fifteen per cent. to twenty-five per cent. alcohol. The addition of glycerine also works admirably in some cases.

Let me cite you a few examples of incompatibility: fluid extract of buchu, spirits nitrous ether, syrup. The tannin in the fluid extract reacts with the nitrous ether and is liable to explode some time after delivery to the patient. Tincture chloride of iron and tincture gentian compound makes an inky mixture.

Fluid extract hydrastis, fluid ertract ergot, water. We may prevent precipitation in this prescription by supplying about one ounce of glycerine.

Precipitated sulphur, balsam peru, vaselin. A homogenous ointment may be made, but it soon separates owing to the insolubility of the Peruvian balsam in the vaseline.

Peroxide of hydrogen is rendered practically inert when used in combination as it acts both as a reducing and oxidizing agent and is incompatible with almost everything.

Pepsin is incompatible with alcoholic preparations.

The salts of cocaine are decomposed by hot water.

I thank you for the privilege of being with you and I know my place on the program could have been filled to better advantage, I offer you my efforts in the same light as an orderly in the English army, who being questioned by the Chaplain on the occasion of the death of Hopkins, a soldier, at the failure to call him before the soldier's death, replied:

"I didn't think you ought to be disturbed for Hopkins, sir, so I just soothed him as best I could myself."

Chaplain: "What did you say to him?"

Orderly: "I sez, Hopkins, you are mortal bad."

"I am, sez he."

"Hopkins, says I, I don't think you will get any better."

"No, sez he."

"Hopkins, says I, you are going fast."

"Yes, sez he."

"Hopkins, says I, I don't think you can go to Heaven."

"I don't think I can, sez he."

"Well then, Hopkins, says I, you will go to hell."

"I suppose so, says he."

"Hopkins, says I, you ought to be very grateful as there's a place pervided for you, and you have got some where to go."

"And I think he heard sir, for he just gave a little groan, turned over and died."

*ORAL HYGIENE.

E. E. BRISTER D.D.S.,
GULFPORT.

We are today in the whirlwind of a movement for conservation; much is being said and written on efficiency in every line of business; the efficiency of the working man is being improved upon by scientific construction of machinery. The conservation of our natural resources is a national question; and while much is being done to better the condition of everything of commercial value by our National Government, she is neglectful in many ways regarding the health of her people, especially is this so in regard to our infant mortality; according to statistics it is better to have the small-pox than to be a baby. So much for a prelude, which is, too, a slight digression from the subject.

The question of oral hygene is not today the innovation that the many meetings which are being held the world over in its behalf would seem to indicate. As far back as we have history of medicine and surgery you will find mention of it. Solyman Brown who in 1833 inscribed a book of verse to one Eleazar Parmley, Dentist, showed his farsightedness and appreciated its importance; an excerpt from this reads as follows:

But when from loss of teeth the food must pass,
A crude and rigid and unbroken mass,
To the digestive organs, who can know
What various forms of complicated woe
May rise terrific from that single source?
For nature once resisted in her course
Breeds frightful things—a monstrous progeny!
Consumption, fever, palsy, leprosy
The hobbling gout that chides at every breath
The lingering pace of all-destroying death;
And apoplexy, dragging to his doom
The half-surviving victim of the tomb.
See thus the normal life of erring man
Reduced by vice and folly to a span;
And years of joy allotted him below
Exchanged for fleeting months of bitter woe!

The greatest difference between the teaching of hygiene of those early days and the present is the fact that it was only taught to those who were cutlivated, intelligent and had finan-

*Read before the Harrison County Medical Society.

cial ability to take advantage of the teaching, and it was then left with the individual whether they should avail themselves of this opportunity. Today the importance of a clean mouth and teeth is very early impressed upon the school child both by those in charge in the school-room and by the dentist who is becoming recognized more and more as an authority on this question. There is a marvelous process of waste and repair solved in the alimentary canal; the domain over which we preside is the entrance, but we should not be so narrowed that we would allow our perception to reach no further than this area. Our highest efficiency is realized only when we can look beyond this door and know the relationship to the other organs of the body both in health and disease.

The child of an anaemic appearance, with coated tongue and fetid breath too often gets a dose of calomel instead of having the cause removed; this condition is most likely to appear at that age when the deciduous molars are loosened or some carious teeth make mastication difficult thereby causing the child to bolt the food with its train of evils incident to malnutrition and this in turn resulting in retarded development; such mouths are often festering masses of micro-organisms.

Another source of oral infection is mouth-breathing, not in a direct manner however in every case but might be defined as contributory, such conditions are indications of obstructed nasal passages, usually due to adenoids, and if allowed to continue will result in protrusion of the teeth, the characteristic high arch producing malocclusion of the teeth thereby causing pus formation and pyorrhoea.

The most prolific source of pus formation in the mouth might in my estimation be attributed to that scourge of the human mouth, pyorrhoea alveolaris; it is highly probable that it is contributing its quota of ailments to an extent never dreamed of to the human race; in this enlightened age shall we remain indifferent to the results that are likely to follow the introduction into the alimentary canal, food so thoroughly incorporated with pus causing possibly some gastro-intestinal affection from absorption of toxines?

We should not temporize but should deal with this trouble in a more radical manner than is usually followed. Doubtful teeth should at once extracted and all others that we attempt to save by treatment if they do not very soon show some decided improvement in the surrounding tissues, whether peridental membrane or alveolus, also should be removed. The extraction

of such teeth is not too great a price to pay to remove the cause of pus formation.

I have tried to show in as brief a manner as possible the various pus-forming sources in one's mouth, and whether it arises from blind abscesses or from one with a fistulous opening or from whatever source, let us not forget the results that are likely to follow its introduction in the alimentary tract and do all in our power to eliminate this. Can any amount of digestive ferment or intestinal stimulant administered by the physician counteract the slow form of toxemia that ultimately results?

*GONORRHOEA

E. R. McLEAN M.D.,
CLEVELAND.

This subject never grows old to the general practitioner, but often tiresome, discouraging, unfaltering energy and persistence on our part to cure a worthless, ungrateful, disobedient, filthy and rotten piece of humanity.

This subject is not for the other specialists, although it is often found mixed with nearly every other ailment, it is a fact that we find it in nearly every part of the human body, destroying the life of the infant, destroying the future of many a home, destroying the vigor of man, and is the greatest curse that was ever visited on any human.

In beginning this year's work, it was my aim to see if it was in my power to cure lot of chronic cases that I felt were really needed in our midst, these I did not go out and hunt up, because there are always plenty ready to take the treatment if you will promise them a guarantee cure, this I did to my sorrow, it was to see if it was possible to cure them sound and well in a few months' treatment.

The first case that I began on, lasted for nearly three months, he received daily irrigation of the bladder and penis of a strong solution of permanganate followed with dilitation as needed, in addition to this was given santal oil and other internal remedies as freely as the stomach would permit, so after about three months' treatment he was pronounced cured and has not had any return of the discharge but has had several slight attacks of pericarditis that I can't help but believe are

* Read before the Clarksdale and Six Counties Medical Society.

due to the old gonoccoci buried there to follow him to his grave.

The rest of the cases have resulted much better and had the same treatment, except the addition of the serum treatment, which, I am sure, has been the greatest help of all, now it is not claimed by all that it will cure any case of gonorrhea, and really it is doubtful in my mind if it will cure a single case alone, but with the weakened condition of the germ after giving it you have a better fighting chance to kill them with local treatment as well as internal, and there are lots of cases that have not shown any benefit at all with all the other treatments combined, these few are the ones that I want to ask the reason why.

On Aug. 21st. of this year, a young man came to my office immediately after he saw any discharge, there was not any pain, had not been until this day, there was a free discharge several days after I began treatment, with some swelling, I began irrigating the penis but did not go into the bladder for several days, then used about one-half gallon of permanganate solution and used a sound as needed to prevent stricture with antacid treatment which kept the urine soft and non-irritating, in addition to this massaged the prostate occasionally without any benefit at all for two weeks, then I began the serum, began with fifty million and doubled until I gave four hundred million, which were given about four days apart, still no improvement, continued the same treatment of the serum about two then gave him another treatment of the serum about two weeks ago and now there is a small discharge every morning of pure pus, no enlargement of the prostate and very little stricture , if any.

Now in behalf of this patient I want to state that there was never a more obedient, faithful and willing patient to treat than he. and with all this I have not completed a cure, if he had drank or dissipated in any way it would relieve the responsibility and give me a chance to blame him for not gettting well.

The greatest benefit that I have had in all the cases that I have treated this year was with the serum in a case of acute prostatitis with such swelling that I had to draw his water for several days, but as soon as I began to serum the inflammation subsided and I had very little trouble with after-treatment and no bad results at all, with a complete recovery as well. as time has shown.

In addition to all the new local treatments as well as constitutional and serum treatment, it seems to me that with the

vast amount of money that has been spent on other infections diseases the government should appropriate money enough to find a cure for the benefit of the nation as it is far worse than tuberculosis, diphtheria, typhoid fever or any of the infections or contagious diseases; it, as said in the beginning, destroys the very life of a nation without the public knowing it, it should be free treatment to every man, woman or child that is not able to afford it, with a small allowance or salary to the county health officer to give it, or some other salaried man in each county.

As we all know the Six Counties Medical Society has one of the kind of men that does things at the head of it, and a man that we are proud of for his past record as a legislator; why not ask the State of Mississippi to appropriate so much for a free clinic or hospital with a few volunteer students to find a certain cure.

This it seems to me would interest the public and benefit future generations more than the eradication of the boll weevil, ticks or animal gems.- Suffering humanity seems to be the last one on the list, but I hope to see the day that America will be cured of gonorrhea.

*TUBAL OR EXTRA-UTERINE PREGNANCY.

J. H. CARTER M.D.,
MEMPHIS, TENN.

There are but few subjects in the whole range of medicine that excite more interest, both to the general practitioner of medicine and the surgeon, as tubal or extra-uterine pregnancy.

Of all the phenomena of mysterious processes of life, the most mysterious is that an ovum becomes impregnated and developed into a living child other than its normal development. Therefore, this extraordinary phenomenon is great and becomes more so by the fateful possibilities of the situation as well as the dreadful outcome which may at any time determine a doubtful diagnosis and rob the poor victim of her life.

For these reasons and that nearly all cases, in the first stage, fall into the hands of the family physician, it is therefore important that we should know more about the subject and be able to make correct diagnosis and not wait for the surgeon and proper means for their relief.

Until the past few years, tubal or extra-uterine pregnancy was thought to be extremely rare, but it is now known to occur

*Read before the East Mississippi Four County Medical Society.

quite frequently if not common. There are but few physicians who have been in practice for the past ten years who have not seen or heard of a case. It has shown that many of these cases of irregular menstrnation associated with colic, tympanitis and pain on standing, which pass off without any treatment, other than a purge and hot douches—are all in reality a mild attack of tubal pregnancy.

For these reasons, any irregular or deviation from the normal during gestation should arouse our special attention. It may be said that tubal or extra-uterine pregnancy in its early stage belongs to the family physician, but as soon as the diagnosis is made it should be transferred to the surgeon.

After we have seen one case, the diagnosis thereafter is more quickly made. In order to make a correct diagnosis and grasp our subject properly, we must know the cause and the course, if left alone, in tubal pregnancy.

Dr. Kelly states that extra-uterine pregnancy occurs in any one of the five places along the tube: from within outwards:

1st. In ovary.

2nd. In the tubo-ovarian fimbria.

3rd. In the ampulla.

4th. In isthmial.

5th. In the interstitial portion of the tube.

The most common is the ampulla and next isthmial. The interstitial form is rare and of the ovarian, only a few have ever been seen.

Cause: It is now thought that the spermatozoa travel up

Cause: It si now thought that the spermatazoa travels up the uterine wall, enter the tube and down until they meet the ovum at or near the ovary, this by their own volition of propulsive movements, while ovum, which is much larger, must be carried out through the different parts of the tube by other propulsive power. Therefore, anything that would have a tendency to stop or retard the movement of the ovum along its course, might be said to be one of the causes of tubal pregnancy.

Namely:

1st. Any pelvic adhesions may bind the tube down or bands running across the tube producing a loop that would obstruct the progress of the ovum.

2nd. Tumors of the tubal mucosa or fibroids of the uterine cornua blocking up the isthmial of the tube.

3rd. Tubo ovarian cyst by causing a twist in the tube.

4th. Webster states that inflammation of the tubal mucosa

by which its cilia are destroyed, which are the propelling power of the ovum.

5th. Diverticula in the tube sometimes stop the ovum.

6th. The long narrow, winding tubes that are found sometimes in normal women is said to be a cause.

7th. Any pressure from within or from without that would cause a blocking of the calibre of the tube would be a cause.

From these facts it will be seen that not one but many causes operate to bring about tubal pregnancy, which are not confined to a woman of a particular locality but are found wherever there are women to become pregnant.

To say what the direct cause is in any one particular case can only be determined at the operating table or pathological laboratory, even then it is impossible in some cases.

The operating room has proven one thing: that women who have had one extra-uterine pregnancy are more liable to another and that they rarely occur in the normal, that is, one that has not had some trouble or irregularity during her menstruation. Therefore, we should watch after these women very closely.

Accidents which may happen to the ovum are many. It usually always ends by violent death, caused by rupture of its sac, tubal abortion, when it slips out into the abdominal cavity: sometimes, the ovum becomes encapsulated by hemorrhage which cuts off its nourishment and therefore dies. It is very rare that the fœtus goes on to term. The false labor pains come on and if the correct diagnosis is not made and the fœtus removed by abdominal section, it dies and begins to undergo degeneration of mummification and lithopedion formation may take place in the fœtus. Rupture may take place into the broad ligament, peritoneal cavity.

I have seen five cases in the past five years. Four of these were my own, the other while an interne at the Memphis City Hospital. One to full term, two four months and two six weeks, all of which I shall report at the conclusion of this paper.

Diagnosis: I might say the symptoms before and after rupture. Before we usually have a woman that gives the history of a suspicious pregnancy, that she has not been as regular for the past two or three months with her menstruation as usual, sharp cutting pains in the side where the pregnancy occurs; menstruation may come each month but scant, may pass shreds of mucus and endomertium. Very frequently, there is more or less pain during intercourse, especially a soreness a day or so following, exciting menstrual flow. Increase in size of

abdomen, more noticeable on one side and seems to be a little higher than in normal gestation. Occasionally, the woman may pass off great chunks of endometrium, thereby suspect she has aborted.

Tubal or extra-uterine pregnancy usually occurs in women that have not borne children for some time and have more or less trouble during their regular monthly sickness.

On external palpation, we will find a tumor usually situated to one side and boggy like to touch and not so symmetrical in shape and outline.

Bimannal palpation usually confirms what we found as above with more or less pain when pressure is exerted on the tumor. We also find the uterus somewhat enlarged but not in proportion as it would be in uterine gestation.

After rupture, the first symptoms are pain, cutting in nature, coming on suddenly and situated to one side with more or less shock. Of course, this would be governed by the amount of hemorrhage following the rupture, at this time or soon after, we have a bloody discharge from the uterus.

Tubal or extra-uterine pregnancy might be mistaken for appendicitis or an ordinary uterine abortion and salpingitis, but from careful history and study of case, the correct diagnosis can be made.

Treatment: I might say is surgical but there is much can be done while waiting for the surgeon to arrive.

If rupture has taken place into the abdominal cavity, there will be profuse hemorrhage and we have but little time to wait. Therefore, put patient in bed flat on back, arms and legs bandaged to shoulders and hips, ice packs over the abdomen, saline transfusion under breast (fountain syringe will do if we have nothing better) attached to aspirating needle. Also have foot of bed raised and saline by rectum and morphine to keep patient quiet. Adrenalin, twenty to thirty minims to a pint of saline, is useful.

Rupture in other parts is treated in the same way but less heroically.

I will not go into the surgical technique but to say we should operate in all cases as soon as possible as we never know when hemorrhage is going to take place even if it has seemingly been stopped.

The five cases which I have seen, four of which were my own, were operated on by myself, two being about six weeks' duration and the other two four and one-half months, all patients recovering.

The fifth, I saw while an interne at the Memphis City Hospital to which I had the opportunity of being the assistant, occurred at full term. The operation being done during shock, the patient died in a short time.

In conclusion, I wish to insist upon a careful diagnosis of each case of suspected tubal pregnancy as early as possible, thereby giving the patient a much better chance of her ife.

*DIFFERENT EFFECTS OF PURGATIVES.

S. W. GLASS M.D.,
LYON.

The subject of different effects of purgatives opens the "gateway" for an endless investigation to well and forcibly realize the importance of a correct understanding of this class of drugs, for here lies with the delta physician his chief avenue to success. With us the main features of treatment are eliminative and supportive. We never stop to study the physiological effect of different purgatives. They occupy such an important place in the treatment of diseases and have been and are so extensively used that it would seem that the principles upon which their actions depend would long since have become a matter of common knowledge.

Before discussing this paper we should bear in mind that the action of every purgative is dependent upon its action on the motor or secretory activity of the intestinal canal.

There are several means of stimulating or arousing either the motor or secretory activity of these glands. First, we have a mechanical stimulation which is composed of massage of the bowels, also stimulating applications which to a greater or less extent have their physiological effect. This includes the external application.

I wish briefly to call attention to the different effects of purgatives. They are divided into several groups according to their nature of action; namely laxatives, saline purgatives, mercurial purgatives, tonic, astringent and resin bearing purgatives and hydrogogue purgatives.

First, consider the action of laxatives. They stimulate the intestinal movements without increasing the intestinal secretions to any considerable extent. Saline purgatives differ from this in effect inasmuch as they increase the activity of the intestinal glands. Mercurial purgatives, chiefly calomel and

*Read before the Clarksdale and Six Counties Medical Society.

blue mass, exert an influence to themselves. At present they are supposed to cause an excretion of bile, thereby proving an hepatic sedative and not a stimulant. Tonic, astringent and resin-bearing purgatives increase the action of the liver and glandular appendages of the gastro-intestinal canal and increase the tonicity of the muscular layers of the intestinal canal.

Hydrogogue cathartics act with great energy and not only increase the glandular secretions but cause a very abundant outward diffusion, so that the dejections which they produce are extremely watery. This group of purgatives also excite a very rapid and violent peristaltic movement.

My purpose in writing this paper is to emphasize the fact of our neglect of materia medica. After we have finished our college course our materia medicas are least considered. The statement has frequently been made "Be sure to make a correct diagnosis and the treatment will suggest itself." This is no doubt erroneous and misleading. How many today fully understand the physiological effect of calomel and quinine? In the South they are the physician's "Best Man."

The common advice of the average physician to his patient is "Take something to keep your bowels open," never pausing to consider the pathological conditions existing, or the physiological effect of different purgatives. Suppose you had a case of violent gastro-enteritis. Would you attempt to give some irritating drug? I make the statement that you would not, so I impress you with this fact: don't prescribe for your patient until you fully understand the physiological effect of your drugs and the pathological condition existing.

The American Surgical Association has appointed a Committee consisting of Drs. William L. Estes, South Bethlehem, Pa.; Thomas W. Huntington, San Francisco, California; John B. Walker, New York City; Edward Martin, Philadelphia; and John B. Roberts, Chairman, 313 S. 17th Street, Philadelphia, to report on the Operative and Non-operative Treatment of Closed and Open Fractures of the Long Bones and the value of radiography in the study of these injuries. Surgeons, who have published papers relating to this subject within the last ten years, will confer a favor by sending two reprints to the Chairman of the Committee. If no reprints are available, the titles and places of their publication are desired.

Letter to The Editor.

Clarksdale, Miss., Dec. 10, 1912.

Editor Mississippi Monthly:

My Dear Doctor: Please do not publish in the Mississippi Monthly the paper read by Dr. Frank D. Smythe, at the Clarksdale and Six-County meeting on November the sixth, entitled, "Report of a Case of Corio-Epitheliomata, With Remarks on the Malignant Diseases of the Body of the Uterus." The following letter of explanation from Dr. Smythe is sufficient to show why said paper should not be published as having been read at the Six-County meeting. These letters are for publication.

Very truly yours,

T. M. Dye,

Secretary.

Memphis, December 7th. 1912.

Dr. T. M. Dye,

Clarksdale, Miss.

Dear Doctor: Replying to your letter of the 4th. beg to say that the paper I read before your Society at its last meeting was read at the meeting in Tupelo, Miss., in August and appeared in the November issue of the *Memphis Medical Monthly.*

I appreciate very much the invitation extended me to visit your Association and contribute a paper and decided that I could not add more to the interest of the occasion than to read the paper that I had carefully prepared on one of the most important subjects in my opinion to a medical man, and felt that as result of my personal experience and investigation of the literature my remarks might prove more interesting and of more benefit than if I had selected another subject.

I regret very much that I was not familiar with your rules and regulations regarding papers presented, as I most certainly would not have violated the wishes of my host. I simply have to ask your indulgence on the ground of ignorance on my part. It is quite a compliment to be invited to deliver an address before a body of medical men, and whether deserved or not on my part, same was fully appreciated and I trust that you will overlook my inadvertent transgression of the rules of your society.

Hoping to have the pleasure of seeing you, or being with you at some future time, I remain, with highest regards.

Your friend,

F. D. Smythe.

MISSISSIPPI MEDICAL MONTHLY.

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OFFICIAL ORGAN OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION AND ITS COMPONENT SOCIETIES.

SUBSCRIPTION ONE DOLLAR PER ANNUM.

The secretary of the State Association is in receipt of the following:

"Jackson, Miss., Nov. 28th. 1912.

"DR. E. F. HOWARD, Secretary,
"Vicksburg, Miss.

"Dear Dr. Howard—In view of the confusion arising every year because of the tardy payment of state dues, the Council requests you to communicate at once with the county secretaries, urging them to make all possible collections by January 1st. and to send their remittances and rosters of members to you on or before February 1st. next.

"This plan, if followed by the county secretaries, will enable the committee on program to prevent errors in arranging the program for the meeting. Heretofore non-members have often been placed on the program.

"The A. M. A. requires a list of the bona fide members of the Association in time to arrange for its annual meeting, and this cannot be done unless the lists are in your hands earlier than has been the custom in the past.

"We trust you will attend to this matter at once as the Council regards it as urgent.

"Very truly yours,

T. M. DYE,
"Secretary Council."

Copies of this have been sent to all the county secretaries. The reasons for the request are so clearly stated in the letter that further comment is unnecessary. Naturally no one need comply with the request unless he sees fit to do so, no one who does not comply will be dropped from the roll or lose any part of the benefits of his membership, but it is hoped that all will see the advantages of compliance and make the work of the county secretaries, who are the wheel-horses of the organization, as light as possible by "coming across" promptly.

Every once in a while we hear of a case in which a physician, through carelessness, has been the cause of some poor devil acquiring the opium habit. As a general proposition we do our profession the honor not to believe the story but sometimes it comes from such high places that we can't demur, witness the following from an editorial in the *Journal A. M. A.*, discussing the prevalence of the heroin habit:

"Even physicians are not sufficiently alive to the danger of habit from its use. In one instance a patient told a physician, who was called to treat him for an attack of laryngitis, not to give him anything that contained opium, because he had formerly been a slave to this drug. The physician replied: 'I will give you some heroin; there is no danger of habit from that.' This the patient took, with the result that he later had as much difficulty in breaking away from the heroin as from the opium habit."

This story at first blush appears rather too improbable until we note that it isn't told as hearsay evidence but as having been noted by the writer. Therefore the physician's name should have been given for no association that undertakes malpractice suits can afford to have him on its roll. He is too recklessly unsafe a risk.

Society Proceedings.

East Mississippi Four-County Medical Society met at Tupeo, December 17th., 2 P. M.

The following was the program for the occasion:

Invocation, Rev. W. L. Duren; President's Address, W. N. Reed, Smithville; Some facts in relation to the surgical treatment of the near dead, discussion opened by Drs. Bryan, McMillan, Elkin and Durley; Better health conditions for the country and how obtained, J. O. Gurney, Tupelo, discussion Drs. Boyd, Reed and Wilson; A paper on Tuberculosis, C. T. Keyes, San Angelo, Texas, discussion Drs. Wicks, Bonner, Lee and Burdine; Report of some cases of typhoid with unusual complications, Drs. Toomer and Stone, Smithville, R. 3, discussion Drs. McCowan, Carruth and Green; A clinic—mitral regurgitation, F. J. Underwood, Nettleton, R. F. D., discussion Drs. Feemster, Farrar and S. C. Spencer; Clinics by Tupelo Doctors, discussion general; Annual election of officers; Banquet at Reed House.

Jasper County Medical Society has elected officers for 1913 as follows: J. W. Stringer, Stringer, president; G. W. Land, Louin, vice-president; C. E. Burnham, Bay Springs, secretary-treasurer-delegate. The society reports the loss of one member as compared with last year. This is the first society to

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*THE CAUSE AND PREVENTION OF TYPHOID FEVER FROM A PUBLIC HEALTH VIEW-POINT.

J. T. LONGINO M.D.,
JONESTOWN.

It has been said that typhoid fever is a disease of civilization; that wherever civilization advances typhoid fever becomes more prevalent. This is an erroneous idea and should better be stated that typhoid fever is due to a lack of civilization; because if people are highly civilized they are better educated in the science of preventive medicine and better sanitary measures are usually enforced.

Typhoid fever does usually increase where population increases, but this is true only where poor sanitary conditions prevail.

Typhoid fever, whenever and wherever it may occur, is always due to one essential cause, namely, typhoid bacilli, and under favorable conditions they live and multiply rapidly. Under unfavorable conditions, they remain quiescent, or if conditions are sufficiently unfavorable, or prolonged, they die.

The portal of entry into the human body is the mouth.

To use a common expression typhoid fever is swallowed and not caught. When typhoid bacilli enter the body through the mouth, they may reach the intestines, multiply there and give rise to typhoid fever.

The entrance of the invasion is somewhere in the alimentary canal, probably always in the small intestine, but some writers have suggested that the tonsils are also often the point of entrance.

Through slight abraisons in the intestinal wall, or in some other manner at present unknown, the bacteria invade the structures of the intestinal wall. The lymphatic tissues are invaded and there occurs swelling and later ulceration of the lymphatic structures, known as Peyer's and solitary glands. The mesenteric glands are invaded and from these the bacteria

*Read before the Clarksdale and Six Counties Medical Society.

are carried into the general circulation and to all parts of the body.

In autopsies, the typhoid bacilli have been isolated from the mesenteric glands, spleen, bone marrow, bile, and from pus and other fluids from various parts of the body, and in many cases they may be isolated from the blood during life, showing that typhoid fever is a general infection, and is a bacteræmia as well as a toxæmia.

Typhoid bacilli can be isolated from the excretions, the feces, urine and sputum, of all persons infected with disease.

All evidence available indicates that the human body is the only natural breeding-place of the typhoid bacilli.

Wherever else the typhoid bacilli may be found in nature, we may safely consider that they have recently come from some infected individual. Outside the human body the typhoid bacilli do not live but a short while. To this statement there is one important exception. Milk is a favorable culture medium for the typhoid bacilli and at the proper temperature and other favorable conditions, they live and multiply rapidly.

As to how long the typhoid bacilli live outside the human body, depends largely on surrounding conditions. Under the most favorable conditions they may live for months, but under ordinary circumstances, after leaving the body and coming in competition with various other organisms, or the ordinary saprophytes with which the excreta soon become infected, and exposed to the changes in the temperature of the outside world, and exposed to the sunlight they die within a few days.

It has been demonstrated that in flowing water, typhoid bacilli live only eight to ten days. In sewage-polluted water, they live scarcely half that long.

Whether typhoid bacilli can multiply in water is uncertain; certainly they do not ordinarily do so.

Typhoid bacilli are discharged from the bodies of infected persons in the excreta, and these excretions are the sole and only source of typhoid fever. Anything which serves to carry the discharges of infected individuals to the mouths of other people may spread the disease. The prevalence of typhoid fever in any community is proportionate to the chances offered in the community for the contamination of human food and drink with the discharges from the human system.

The typhoid bacillus is dependent upon the human body for its perpetuation, and present in the human body in the following conditions:

In persons sick with the disease. The discharges of such persons always contain typhoid bacilli and constitute a very important source of the disease.

In persons in the very early stages of the disease. Typhoid bacilli enter the body from one to three weeks before the development of any definite symptoms of typhoid fever. They may multiply and be discharged from the body several days before symptoms of the disease are recognized.

In persons who become temporarily infected with typhoid bacilli without developing the characteristic symptoms of typhoid, bacilli multiply in the body causing only slight or atypical symptoms of the disease, the so-called ambulatory typhoid fever. In still other cases the typhoid bacilli have been known to multiply in the body and be discharged in the excretions without producing any symptoms whatever.

In persons recently recovered from typhoid fever. These continue to discharge the bacilli for several days and even weeks after all symptoms have subsided.

In persons who have long since recovered. It is estimated that about two per cent. of all persons, who have had typhoid fever, continue to breed and discharge the germs for several years, and even for the remainder of their lives, the chronic typhoid carrier; and it is this class of cases that presents our most difficult problems in the prevention of typhoid fever.

It is safe to say that every community that has had typhoid fever has its usual per cent. of these typhoid carriers, who are constantly discharging these typhoid germs and disseminating the disease wherever they may go, becoming a constant danger to the health and lives of all with whom they may associate, and a menace to the public health of any community in which they may reside.

The following are some of the many ways in which human discharges, containing typhoid bacilli, are carried to other people:

By contamination of the water supply. The custom of cities discharging their sewage into lakes and streams, from which they take their water supply, has been the cause of many a widespread epidemic of typhoid fever. It was once considered safe for river towns to discharge their sewage into the river provided that the point of discharge was down stream from the water intake, but it is now known that this immense dilution is not sufficient, because this principle disregards the safety of communities situated further on down stream and their

water intake is exposed to pollution. Therefore the solution of this problem necessitates both the purification of the sewage before it is discharged, and the purification of the water supply before it is used. Some of our larger municipalities have made considerable progress along this line and have greatly reduced the prevalence of typhoid fever by devising various means of sterilizing or purifying the sewage and by the installation of filtration plants for the purification of the water supply. The small towns and rural districts present more difficult problems, especially where the open wells and surface springs are still in use. If human discharges containing typhoid bacilli are thrown out upon the ground, they are apt to be washed away by the rains and contaminate open wells, springs, running streams and various other water supplies. Open wells and surface springs should be condemned unless they are sufficiently walled up and covered over to prevent any possible chance of contamination by surface, subsoil or fissure water. The pathetic inscription, "The town well," might be written as an epitaph on many a tombstone.

The vine-covered spring where the wayfarer's thirst has been quenched, and the rock-walled, dug well has filled many an untimely grave.

The poetical old moss-covered bucket has held many a deadly beverage and caused many sad scenes of our childhood.

It is high time for a change from the ancient custom of placing dwellings, barns, privies, etc., where they will drain into a well or a spring, over the surface, through the soil, or through a permeable stratum.

Wells should be drilled, and to such a depth as to prevent all possible chance of contamination by surface or fissure water.

The reason that the Mississippi Delta has enjoyed comparative freedom from typhoid fever epidemics, in the past, is due to the nature of the water supply. The water supply consists almost entirely of artesian wells or the driven iron pump; both of which are closed wells and not exposed to surface contamination.

About the next most frequent source of typhoid infection is by contamination of the milk supply.

Milk may become contaminated with human discharges containing typhoid bacilli if handled by persons who are themselves infected, or who have handled typhoid fever patients.

Milk may also become contaminated from the water, used in any way in connection with the milk, such as for washing

the utensils, or for dilution of the milk, if such water should be contaminated water. Milk may become contaminated from the house flies coming from an open privy to the milk pail.

The typhoid carrier in the employ of a dairy or in any way connected with the handling of milk has proven to be one of the most frequent sources of our typhoid fever epidemics.

Milk bottles left at the houses of typhoid fever patients should be thoroughly sterilized before refilling and use again at the dairy.

Where human discharges containing typhoid bacilli are exposed, the house fly becomes an important factor and great disseminator of typhoid fever.

People who nurse or handle typhoid fever patients, even though comparatively clean, may still carry sufficient traces of infected discharges, on their hands or clothing, to infect themselves or other people with typhoid fever, the so-called direct or contact infection.

Another perhaps less important means of distributing typhoid germs is fruit or vegetables, if eaten raw, after being exposed to flies, dust, etc., or handled by typhoid carriers, or grown on ground over which human excreta has been distributed as fertilizer, or on ground accidentally or otherwise polluted with human excreta.

Some epidemics of typhoid fever have been traced to oysters and shell-fish grown in sewage-polluted water.

Since the discharges from the bodies of infected persons constitute the sole and only source of typhoid fever, the prevention of this disease consists in the proper disposal of all infected human excreta in such a manner that will prevent all possible chance of its reaching and contaminating human food and drink.

Since a great many typhoid infected individuals are unrecognized, the proper disposal of all human excreta becomes necessary.

There are three sanitary methods in use of disposal of human dejecta and some one of the three methods is always within reach of any community: the sanitary sewer, the sanitary cesspool and the sanitary privy.

The length of this paper will not permit a description of each method, but each method, if properly constructed and cared for, is sanitary and permissible, but remember that in each case the dejecta should go though some sterilizing process or be treated with disinfecting agents, before its final disposal.

Large epidemics of typhoid fever always arise from the contamination of some largely consumed article of diet, such as water and milk, and the preventive measures to be carried out must necessarily be under the supervision of boards of health, health officers, and other public hygienists, but since the destruction of the typhoid bacilli, in the excreta of people sick with the disease, constitutes a very important preventive measure, we are almost entirely dependent upon the efforts and co-operation of the attending physician.

The physician by a proper understanding of the principles involved, and the exercise of all his influence with his clientele in carrying out the proper measures, can undoubtedly do more to prevent the spread of typhoid fever than any one else; and it is largely for emphasizing this point that I present this paper to this medical association. Any physician who thinks that his duty is limited to the treatment of disease and the care of the sick, is not worthy of the title of M.D. People rely on their family physician for the benefit of his knowledge and efforts in the prevention of the spread of disease to other members of the family, and for the conservation of their health in all instances where their lives are endangered.

How could any physician conscientiously justify himself, when employed in typhoid fever cases, if the disease should spread to other members of the family, and probably result in death, through his carelessness and neglect.

The following are a list of rules that should be followed by the physician in every case of typhoid fever:

Make the diagnosis as early as possible, and consider every case of suspicious fever as typhoid, till the diagnosis is made otherwise. In every case the diagnosis of typhoid fever should be confirmed by the proper blood test. In the State of Mississippi, with the present advantages offered, by the State Bacteriological Laboratory, to make the agglutination test free of charge, there is no excuse for any physician to fail to have such tests made.

Report every case of typhoid fever to the proper health officer, as soon as the diagnosis is made and solicit his aid and co-operation in preventing the spread of the disease.

Trace, if possible, the source of infection and if found, take the necessary steps to prevent further infection.

Investigate the water supply, and if any suspicion of contamination, the water should be boiled.

Institute a moderate degree of isolation, to prevent direct

or contact infection, allowing in the room only the nurses and necessary attendants.

Keep the patient's room well ventilated.

Remove all unnecessary carpets, draperies, ornaments, etc., from the room.

Do not use a broom or duster in the room as these scatter dust and germs. Clean the floor and furniture with damp cloths or mops, which should be boiled each time after they are used.

The room should be screened and free from flies.

Keep a good disinfectant solution in the room and require the nurses and attendants to disinfect their hands after handling the patient, and require everybody who enters the room to disinfect their hands on leaving.

Do not allow any one to use the glasses, dishes, spoons, napkins, handkerchiefs, etc., which are used by the patient till after they have been sterilized.

Do not take the patient more food than he will eat at one time, and remnants of food left by the patient should not be carried back to the dining-room or kitchen.

Do not allow the patient's nurse or attendants to cook for the rest of the family or have anything to do with the handling of the milk or any other food.

Destroy all the typhoid bacilli in the excreta, in the sick room, immediately after being discharged from the patient. This consists in the thorough disinfection of the feces, urine and sputum.

After a stool the patient's buttocks should be cleaned with 1 to 1,000 solution of bi-chloride of mercury and the patient's hands should be cleansed with some good antiseptic solution.

Disinfect all bedding and body clothing immediately after being removed by boiling at least twenty minutes, or immersing for several hours in five per cent. carbolic acid solution.

Disinfect all water which has been used for bathing the patient, by adding to it carbolic acid or some other good germicide.

Do not allow any member of the family to kiss the patient.

After recovery the room should be fumigated or otherwise properly disinfected.

The patient should be required to carry out the disinfection of the stools during the entire convalescence, and if bacteriological examinations are available, the urine and feces should be shown to be free from typhoid bacilli before the patient is discharged.

It has been shown that the typhoid bacilli occur in the urine in about one-third of all typhoid fever patients and sometimes in enormous numbers. Therefore to be safe every specimen of urine in typhoid fever should be regarded as a pure culture of typhoid bacilli.

For the disinfection of the urine, a volume of urine would require about one-third its volume of a five per cent. carbolic acid solution; one-fortieth its volume of a one to one thousand mercuric bi-chloride solution; one-tenth its volume of a ten per cent. formalin solution; one-fortieth its volume of a chlorinated lime solution.

As to the relative value of these disinfectants, while they are all efficient, carbolic acid probably deserves the preference, due to its cheapness. Formalin, while equally efficient, is hardly serviceable on account of its cost.

Chlorinated lime is objectionable because, when exposed to the air, it rapidly loses its strength.

The disinfection of the stools is more difficult, since frequently the bacteria are embodied in hard firm masses of feces, somewhat impermeable to the action of the disinfecting agent.

It should be remembered that the incomplete disinfection of the stools is dangerous because it establishes a false feeling of safety and probably leads to a more careless disposal of the feces. If the disinfection is not thorough, you just as well not disinfect at all. The solutions most generally employed for disinfection of stools, are milk of lime, chlorinated lime and carbolic acid. The objections to the lime solutions are that if they are not freshly and properly prepared, they are worthless. As in urine, disinfection with carbolic acid is in general to be advised, and should be done by thoroughly mixing the feces with at least twice its volume of a five per cent. carbolic acid solution and allowing it to stand several hours. Another satisfactory disinfectant for the stools is liquid cresol comp. The feces should be mixed with an equal volume of a five per cent. solution and allowed to stand at least one hour.

The ideal method of sterilizing the excreta is by heat, which can be successfully employed where large numbers of typhoid fever patients are treated. Some supply houses have devised sterilizing hoppers, in which steam is used as the sterilizing agent. This or some similar device should be installed in hospitals, military camps and places where large numbers of typhoid fever patients are collected.

Since about two per cent. of all typhoid recoveries become typhoid carriers, patients should be instructed as to such possibilities in their case, and warned of the possible menace that they may become to the health and lives of other people. They should be urged to have the necessary bacteriological examinations made to ascertain whether or not they become typhoid carriers.

The treatment of these cases to prevent the discharge of the bacilli, so far has been without permanent result. Urotropin and mercurial inunctions have been tried in a number of cases with only temporary results. Vaccines have been tried but so far without effect.

It is necessary that these typhoid carriers be instructed and required to make the proper disposal of their stools, disinfect their hands after defecation, and to take the proper precautions in regard to their linen. If the person should be a milk-man or a cook, or in any way employed in the handling of the food or drink of the people, he should be urged and assisted to change his occupation.

We need never expect to control and prevent typhoid fever outbreaks until the proper provisions are made by which these typhoid carriers may be apprehended and treated, or kept under regulation and control.

The length of this paper will not permit the taking up of the subject of vaccination for the prevention of typhoid fever, but suffice to say that while some brilliant results have been attained, yet this method of prophylaxis is, in a measure, in the experimental stage, but we hope that in the near future, it will reach such scientific perfection that the human race may become immunized and typhoid fever be exterminated.

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*AN APPEAL FOR MORE SURGERY AND BETTER SURGERY IN THE COUNTRY.

J. J. WILSON M.D.,
COLDWATER.

I have selected this subject because I have been forcibly impressed that it is the most neglected, and worst abused, branch of medicine. I have had the appalling fact thoroughly demonstrated to me that many lives are lost annually in the country, because the doctor through ignorance, or fear, fails

*Read before the Tate County Medical Society.

to operate on his patient when it is indicated. We are too prone to depend entirely on the specialist and by so doing neglect to make ourselves efficient in this line of work. I think it is just as essential, and even more so, for every one of us to know the technique of an appendectomy, or herniotomy, as it is for us to know how to set a fracture of the femur. I understand thoroughly it is much more difficult for us to carry out our aseptic technique in the country than it is in hospitals, but it most assuredly can be done anywhere where you have water and heat. I also understand how the laity feel about surgery in the country. Who is to blame for this prejudice? No one but we country doctors. If we were as careful about our asepsis as the surgeons are in hospitals, we would never have an infection because our surroundings are much more aseptic. We have fewer septic germs and more of nature's germicides—fresh air and sunshine. I don't mean we should do all of the most difficult major operations, those cases in which you can wait and get better environments and give your patient a better chance. Let the more experienced surgeons operate on them. You all know, and have seen, cases in which you couldn't wait, perhaps ride your patient ten miles in a carriage and then thirty miles on a train, without proving fatal to him. I once received a patient into the hospital who was suffering from strangulated hernia, sent us by country doctors. We operated on the case and found a mass of gangreneous guts. We had to resect several feet of gut and the patient was in such condition that the shock from operation proved fatal. How easy it would have been for this doctor to have cut down on the ring, enlarged it and reduced the bowels before they became gangrenous. I also remember a case in which the bowels had been reduced and the patient died from an injured bowel being pushed back into abdominal cavity. This was no doubt injured by the manipulation in its reduction. There should not be a man present to-night who could not do a Bassini operation for the radical cure of hernia. I will relate to you a case of strangulated hernia on which I operated about two years ago under the most adverse circumstances. The patient was a negro over fifty years of age who had been ruptured for years. Hernia came down on him several days before I first saw him. The attending physician had made several unsuccessful attempts at reducing it, both with and without anesthesia. I reached the patient just before night and found

him suffering excruciating pains. Was complaining of sick stomach and vomiting, pulse was getting rapid and temperature was rising. We immediately decided that operation was the only thing that would save the patient's life, so we began to get things in readiness. The negro lived in a one-room hut, kept "bach," and to say the least of it conditions were most unfavorable. We found an old wash pot which we used for a sterilizer, and everything from sheets and towels to instruments was sterilized thoroughly. Our operating table consisted of two planks taken from the ceiling of his room and two barrels. We placed our patient on this improvised table and did the Bassini operation on him with the following results: a life saved and a hernia cured. I relate this case to show you that you can do surgery under the most adverse circumstances in the country. The thing that makes us fail to do our duty in this line of work is that we don't want to take the responsibility, we want to shift it to the shoulders of our surgical brothers in the city, many times at the cost of the life of our patient. How many patients have died in the country with a general suppurative peritonitis for the lack of an incision in the belly and a drainage tube? Gentlemen, don't ever give a patient up in this condition, give him a chance. Make an opening in the abdomen, put in your drainage tube, sit him up in the Fowler position, give him saline solution in Murphy drip and by hypodermoclysis, and you will surprise yourself in the results you will get. I will relate a case to you which will show you the results you will get in cases which are apparently hopeless. This is the case in which a brother physician had correctly made a diagnosis of acute appendicitis. She was first taken with severe pain in right side over McBurney's point and had a little temperature, about 100° F., for two or three days before I saw her. The mass could be palpated over McBurney's point. On the morning of the day I was called her temperature dropped to subnormal, pulse ran up to one hundred and thirty. She complained of severe pain all over the abdomen which rapidly distended. Mass inside disappeared. I saw her at 9 p. m. of the same day. Temperature was 102⅗, pulse 160, respiration 40. We made a diagnosis of ruptured appendiceal abscess with general peritonitis. We gave strychnine sulphate 1-40 grain hypodermatically every four hours, applied hot turpentine stupes to abdomen, placed her in the Fowler position, gave her saline solution by Murphy drip and by

hypodermoclysis and when necessary gave her morphine and atrophine. She was profoundly shocked all night, was bathed in septic sweat, had that anxious distressed look about the face. At 9 a. m. the next day she was somewhat improved, pulse 136, temperature 102⅖, respiration 24. Pulse still very weak and thready, and she was still in septic sweat. We very wisely decided that if her abdomen was not drained she would surely die. In fact death seemed inevitable in spite of everything, but we decided to give her a chance. We anesthetized her with ether at 11 a. m., made an incision in the medium line about four inches in length, and evacuated at least a quart of pus. On putting my hand into abdomen I found a mass over the appendix which I let severely alone. Placed two rubber drainage tubes in lower end of incision and closed abdomen. Put the patient to bed in the Fowler position, and commenced our saline solution by rectum and by hypodermoclysis. Patient's temperature never did go above 99° again and from this time on her recovery was uneventful and complete. Now this is another case I can say without hesitancy was saved in the country by surgery.

In considering the subject let us not forget the last and most important phase of the discussion: better surgery in the country. In our surgery some of us certainly do not profit by the valuable discoveries of our famous bacteriologists, and protect our patients against these deadly enemies—germs—which our bacteriologists have warned us against. Modern surgery has reached the exalted position it now commands because of the knowledge we have of bacteriology. Without this knowledge we would still be talking and reading about laudable pus and the abdominal cavity would be a field into which few operators would dare to enter. I am afraid a great many of us in doing our surgery forget the old, but true, saying that "cleanliness is next to Godliness." When we realize the full meaning of surgical cleanliness, attain a fair knowledge of anatomy and sum up plenty of nerve, we will surprise ourselves how many lives we can save by operating and draining an abdomen and doing many other operations we once thought no one could do but the city specialist.

If in my feeble effort I could impress upon each of you the importance of emergency surgery, one of the efficient ways whereby human life may be saved, I would feel that I had met in a broad sense my obligation to you this evening.

*GENERAL ANESTHESIA.

H. H. WEST M.D.,
GULFPORT.

Every physician in practice should know how to give a general anesthetic and also realize the gravity and the dangers thereof, and how close he places the patient on the border-line between life and death. I have known some five or six fatalities due to either carelessness or to faulty technique. Doubtless you can recall similar cases to mind. Personally I never begin an anesthetic without an apprehensive fear and dread, and feel relieved when it is over. The morphine and hyoscine and the spinal anesthesia should be left alone by the average practitioner as they are more or less in the experimental stage. Don't experiment with your patients. This leaves us with chloroform and ether for general anesthesia. Ether should always be used unless strongly contra-indicated. No surgeon has a moral right to subject his patient to the dangers of chloroform when ether can be used. Statistics show about ten deaths from chloroform to one of ether in anesthesia; at ten to one the odds are too great. No matter which is used, give as little as possible both on account of the immediate danger as well as the injurious effects that they have on the blood and various internal organs. The method of giving an anesthetic and the apparatus should be as simple as possible, no complicated apparatus of jars, gas bags, etc., should be used. Don't risk the danger of valves or something going wrong. The advantages claimed by such apparatus are warming the gas, measuring the gas, or giving a definite mixture. Always give the anesthetic in a warm room, never give mixed gases and as to the amount given this varies widely with different patients. I prefer to give in a plain, simple, open way, drop by drop, so you can see just what you are giving. Use the simple mask that can be raised in a moment in case of choking or nausea. Don't use a mixture of chloroform and ether. Give separately as they have separate effects on the system and you have no right to subject the patient to the action of two powerful poisons either of which might mask the symptoms of the other. I need not recall the classical indications or contra-indications of chloroform and ether as they are easily found in the text-books. I am only giving you the conclusions drawn from my own experience. I have been giving anesthetics for a

*Read before the Harrison County Medical Society.

number of years and have averaged about five per month for the past year. Patients vary much in their subseptibility to anesthetics and it is best to regard each patient as a law unto himself. It don't take long to find the weak point in each patient whether it be nausea, the heart or the respiration. Whether it requires an abnormal or a minimum amount to maintain anesthesia. I prefer to give a few drops of chloroform at first in order to avoid the unpleasant odor of ether with the accompanying coughing and choking sensations. I give the patient just enough anesthetic to keep him quiet. I believe that this is also enough to avoid any shock from operation. I have seen patients profoundly stupid for a long time after operations, but in every case there was an excessive amount of anesthetic given. I much prefer to have the patient try to move occasionally during operation than to be giving stimulants and using artificial respiration. Profound anesthesia puts the patient too near the border-line.

I condemn the use of any kind of preliminary hypodermics; morphine first because in deep anesthesia you cannot tell how much of the depression is due to the anesthetic and how much to the morphine. I find slow and shallow breathing the rule after preliminary morphine. In case of danger you will find that the patient will not revive readily or respond quickly to stimulants; then there is almost invariably nausea on returning consciousness due to the morphine, not to mention the effects of morphine on the secretions. Instead of giving morphine as a preliminary just to quiet the patient, I think a reassuring talk will quiet enough without resorting to an opiate. I am opposed to preliminary strychnine as it is unneeded. Don't stimulate the heart until you have to, then use brandy, camphorated oil and other quick stimulants in connection with strychnine. If strychnine is given at first and the heart shows signs of failing you cannot get it to respond readily to stimulants. Have plenty of stimulants ready to use in case of need during the operation. In conclusion I will recommend that you use either chloroform or ether separately, without any preliminary drugging; give slowly and carefully; give as little as possible and you will have no trouble, no stage of excitement with struggling and, as a rule, no nausea afterwards.

State Board of Health.

SOME DONT'S FOR REGISTRARS.

Don't fail to report to the State Registrar all cases where persons refuse to comply with the law.

Don't fail to see that all items are answered on each certificate of birth or death.

Don't fail to require the informant's signature and address on every death certificate.

Don't fail to require the signature and address of the undertaker, or person acting as such.

Don't fail to require both a birth and death certificate for stillborn children.

Don't fail to require a certificate of birth for each child born, in case of twins or triplets.

Don't fail to require the maiden name of the mother, not the name after marriage.

Don't fail to require date of birth or death.

Don't fail to require the statement of sex.

Don't fail to require the statement of color or race.

Don't fail to require a statement as to whether legitimate or not.

Don't fail to require the approximate age, when the exact age is unknown.

Don't fail to number birth and death certificates consecutively that occur on or after January 1st. 1913, beginning with Number 1 for the first birth and the first death.

Don't fail to enter each birth and death in your record book the day the certificate is filed with you.

Don't fail to have a sufficient number of all blanks on hand at all times.

Don't send burial or removal permits to the Bureau, as these should be kept on file in the office of the Local Registrar.

Federation of State Medical Boards.

The Federation of State Medical Boards will hold its annual meeting at the Congress Hotel, Chicago, on Tuesday, February 25th. 1913.

Essayists, eminently qualified, will prepare papers upon the following subjects:

"Is Universal Reciprocity to Be Desired?"

"Should Medical Boards Require One or More Years of College Work Preliminary to the Study of Medicine?"

"Should One or More Years in a Hospital Be Required for Admission to the Examination for Medical Licensure?"

"Rules and Regulations Governing Examinations for Medical Licensure."

"Qualification of Examiners."

"What Fee Should Be Required for the Examination?"

"Benefit of Having a Single Federation of State Medical Boards and Method of State Board Record Keeping."

"Means of Keeping Politics Out of State Board Affairs."

These topics are all of practical and vital interest to medical colleges, medical examining boards, the profession-at-large and the public.

Those contributing the papers on these subjects come with years of experience and no medical board can afford not to be represented. An earnest and cordial invitation to this meeting is extended to all members of State Medical Examining and Licensing Boards, teachers in medical schools, colleges and universities, delegates to the Council on Medical Education of the A. M. A., to the Association of American Medical Colleges and to all others interested in securing the best results in medical education and legislation.

The officers of the Federation are Arthur B. Brown M.D., president, New Orleans; George H. Matson M.D., secretary-treasurer, Columbus (State House), Ohio; James A. Duncan M. D., chairman Executive Committee, Toledo.

Personals.

Dr. W. B. McDaniels of Ingomar has gone to Oklahoma.

Drs. E. H. Wesson and H. P. Boswell, recent graduates, have settled at New Albany.

Dr. W. F. Rhodes of Savage has moved to Walls, DeSoto County.

Dr. M. M. Powell, a recent graduate, has located at Independence.

Dr. E. G. Meriwether of Lake Cormorant has moved to Memphis.

MISSISSIPPI MEDICAL MONTHLY.

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OFFICIAL ORGAN OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION AND ITS COMPONENT SOCIETIES.

SUBSCRIPTION ONE DOLLAR PER ANNUM.

The November-December issue of the *Bulletin* of the State Board of Health contains information regarding the operation of the Vital Statistics Bureau that should be carefully considered by everyone. This is going to prove one of the most valuable adjuncts of the State Board and will be of great value to the people of the state, but its greatest possibilities will never be attained unless everyone helps. Registration of deaths can be enforced practically absolutely but registration of births, among negroes and that proportion of whites who postpone calling an accoucher until nature's efforts to effect delivery have failed or some alarming complication is manifested, will not be satisfactory until a good deal of educational work is done. This is one point more in favor of registration of midwives for while the midwife, who isn't absolutely illiterate, and many who are, will be only too glad to show their importance, it would be a safe bet that not a quarter of them, probably not ten per cent., know anything about the registration laws. It is an easy matter to give them the little information needed, as opportunity occurs, and much good will come from it.

There is only one point in the entire matter of registration that doesn't meet our hearty approval and that is in the registration of illegitimate children. The registrar, in the Bulletin, discussing this feature, writes as follows:

> "In making the report of the birth of an illegitimate child, I desire to call your attention to Rule 22, Item 7, of the Rules and Regulations, which provides that in case of the birth of an illegitimate child, the

information concerning the father is not required, therefore, when we receive a certificate at the central office with no information concerning the father, and the statement that the child is illegitimate, we will consider such a certificate complete. The Rules and Regulations does not require this information in such cases."

Of course it is a pretty well accepted fact that the great majority of illegitimate children in Mississippi are born to negro mothers, but would not requiring the names of both parents be a step towards reducing the number of mulattoes, quadroons, etc., that are so very much in evidence? As a matter of plain morals we see no reason why any woman, black or white, should be put on the public records as being the mother of a bastard when its father's name is not recorded. We are not posted on the laws of inheritance, rights of children, and other things of the sort that make registration advisable, but surely a bastard child should have the same claim on its father that it does on its mother—legal claim, we mean, for a kindly nature has so constituted women that the illegitimate child frequently gets about the same care and attention, and often affection, as would a legitimate child of the same mother. All of which is purely academic and not referred to the consideration of the legislature.

Society Proceedings.

East Mississippi Four-County Medical Society met in the Court House at Tupelo Tuesday, December 17th. Dr. W. C. Spencer of Verona was selected as temporary chairman, the president, Dr. W. N. Reed, being absent. The invocation was said by the Rev. W. L. Duren, pastor of the First Methodist Church of Tupelo. A motion by Dr. G. S. Bryan prevailed that the society telegraph Dr. J. A. Crisler of Memphis its regrets at his inability to be present. On motion Dr. L. C. Feemster, the regular order of business was suspended and clinics presented first. Drs. Spencer, Elkin and Underwood each presented a clinic and Dr. Gurney several. Dr. Toomer reported several cases of typhoid with unusual complications. Dr. Gurney read a paper on "Better Health Conditions For The County And How Obtained." Discussions on clinics, reports and papers were general and interesting. The Monroe County

delegation nominated Dr. C. B. McCown of Prairie for president and he was unanimously elected. Vice-presidents were chosen as follows: for Chickasaw, S. H. Goyer of Okolona; for Itawamba, W. A. Toomer of Smithville; for Lee, M. M. McMillan of Guntown; for Monroe, B. C. Tubb of Smithville. The following were chosen delegates to the State Medical Association: Chickasaw, A. F. Wicks, J. C. Walker alternate; Itawamba, W. A. Toomer, W. N. Reed alternate; Monroe, W. J. Grady, R. M. Boyd alternate. Dr. F. J. Underwood was re-elected secretary-treasurer. The wife of Dr. A. F. Wicks and the mother of Dr. J. T. Dobbs having died recently, the chairman appointed a committee of three to draft resolutions of condolence. The society then adjourned to meet at Houston the third Tuesday in January, 1913. After adjournment the local members tendered the society a banquet at the Hotel Read.

F. J. Underwood.

Clarke-Wayne Medical Society held its regular meeting in Waynesboro, December 18th. After a supper, and a very interesting program, the chief feature of which was a paper on "The Treatment of Syphilis" by Dr. J. T. Irby of Enterprise, the following officers were elected for the ensuing year: President, J. F. Pou, Waynesboro; vice-president, J. T. Irby, Enterprise; secretary-treasurer, Albert Hand, Shubuta; delegate from Clarke, J. T. Hosey, Enterprise; delegate from Wayne, J. F. Pou, Waynesboro.

Albert Hand.

Harrison County Medical Society has elected officers for 1913: president, A. F. Caraway, Gulfport; vice-president, B. Z. Welch, Biloxi; secretary-treasurer, D. J. Williams, Gulfport.

Hinds-Rankin County Medical Society has elected Dr. R. S. Curry, Jackson, president, and Dr. J. H. Fox, Asylum, secretary for 1913.

Marshall County Medical Society reports a membership of fifteen, the same as last year, and the following officers: N. E. Greene, Holly Springs, president; A. M. McAuley, Marianna, vice-president; W. C. Elliott, Holly Springs, secretary-treasurer-delegate. The new members reported are H. C. Dorsey of Lamar and C. C. Greene of Barton.

Tippah-Union County Society has elected officers for 1913 as follows: president, R. M. Adams, Ripley; vice-presidents, L. P. Pearce, Falkner and E. H. Wesson, New Albany; secretary-treasurer, H. P. Boswell, New Albany; delegates, C. M. Murry, Ripley, and H. P. Boswell, New Albany.

COLLEGE ATHLETICS IN AFTER-LIFE.

In answer to the question "Does the physical training of the college athlete better fit the business or professional man for his after-life?" Harlow Brooks, in a paper read before the New York Medico-Surgical Society, says that he has had frequent opportunity to test this question during a period of fifteen years. As medical officer of a regiment of the national guard composed largely of ex-college men, he has had opportunity to examine them and to oversee their military work anywhere from five to fifteen years after they have left college. During one year he examined in this organization twelve different men, all at one time famous as college football players, six of them captains of their teams. These men were subjected to the same work and the same physical tests as men who had passed through their college course without particular athletic distinction or who had never been in college. Of these twelve famous athletes only one could be rated physically up to the average of the men of his own age. This one subsequently died in the early thirties of diabetes mellitus. Brooks says that similar conditions obtain with regard to men who were active in other college sports, and that the defects become even more marked in trackmen and in oarsmen particularly, but appear in the least degree in baseball players. He says that the experience of other physicians connected with athletic clubs is similar to his and that the distinguished college athlete after ten years of severe business life is below the average man physically, and also in the measure of his resistance against disease. He may even fall below the level of the entirely non-athletic man. The defects, as Brooks has observed them, are confined chiefly to lesions or disturbances of the heart and other circulatory organs, to adiposity or to joint-disease. Brooks attributes this largely to the fact that these athletes, when they engage in business, must large give up their athletic exercises, and it is the law of physiology that a useless tissue deteriorates rapidly. The physical descent of the crack college athlete, Brooks believes, is much more rapid than that of the purely untrained man who has exercised during his youth for pleasure or for benefit alone and who has had no record to maintain.—Harlow Brooks in *Am. Pract.—Journal A. M. A.*

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*LA GRIPPE.

J. J. STEVENS M.D.,
HATTIESBURG.

I am asked by the program committee to read a paper on grippe. Possibly this may be an indefinite term, since we often speak of grippe to express rather indefinite cases.

Quite recently in our epidemic here I have often asked myself whether I was really dealing with influenza, which we suppose to be due to a definite bacillus, or if it might not be a catarrhal fever the cause of which is still indefinite and not believed to be caused by any known organism. We find that the profession and the laity call cases differing widely in symptoms and in intensity, grippe.

Even authorities do not seem to be sure that all cases of influenza vera are due to the bacillus of Pfeiffer since pneumococci, streptococococci and stphylo-cocci are constantly found in the respiratory forms of influenza.

To be sure we do not get the secondary infections in influenza that we can demonstrate the Pfeiffer bacillus in, but on investigating recent literature I find some doubt existing as to the bacillus of Pfeiffer as a primary cause always.

I confess I do not know this bacillus well enough to even think of searching for him and clinically I must class my cases by symptoms.

Clinically the diagnosis rests upon the epidemic prevalence of the influenza, its tendency to great prostration and the prominence of its nervous manifestations.

Attempts to group cases have been successful but we do in practice recognize types. The most prominent type is thoracic or respiratory. Here the variation in intensity is wide. From a naso-pharyngeal and mild febrile case to the severest bronchial and pneumonic cases which may be prolonged by secondary infections that are very severe and so com-

*Read before the Forrest County Medical Society.

plicated that we hardly know the case as one of primary influenza.

These respiratory types give us our nasal and bronchial troubles that lead to many and various troubles. Infected antrums, middle ear and meningeal cases, post-pharyngeal abscesses, dental and supra-orbital neuralgias and the bronchial infections.

I have had in this epidemic three cases of pharyngeal abscess, several cases of dental neuralgias with abscessed teeth, one case of optic neuritis and associated iritis, but the majority have been bronchial. I find these bronchial cases rather hard to cure, especially the sub-acute forms and the more chronic cases.

These sub-acute cases usually come to the doctor after they have run the gauntlet of the drug stores, have had all kinds of nauseating expectorants and have upset their digestion and prolonged their trouble. These cases I have found to be benefitted by two drugs: creosote and iodine. The creosote is not only sedative to the stomach and antiseptic, but seems to exert almost a specific action on the bronchial mucosa. I sometimes give it in the form of carbonate, but do not find it any better than the crude drug. Iodine we all know is eliminated largely by the saliva and bronchial mucosa. I depend upon either the potassium, sodium, ammonium or strontium salts. If the stomach is rebellious I use the sodium or strontium, especially in nervous cases. The ammonia salt is my favorite as it corrects the depression. I always add the hypophosphites and possibly petroleum emulsion. I regard these as the ideal expectorants for these cases.

The respiratory merging into the nervous demands the salicylates. The secondary infections may demand specific attention, and I am now giving such a case, one of the streptococcic infections, the strepto-bacterin. I feel quite sure some of these cases go for months and are called very often acute tuberculosis and I am convinced when we have a staphylococcic infection the case runs a chronic course, is usually lobular in haracter and easy to overlook, the staphylococcic being more disseminated and easier to locate. To be sure we also have lobular infection by the pneumococci and these cases all demand in our day a careful examination of sputum if we are to say what specific medication to use.

In the cardiac types of grippe, the vaso-motor types, we seem to have a toxin in the blood that is a knockout blow to the cardiac muscles and its nerve supply. These types merge so

closely into the nerve types that we all see them therapeutically with our minds made up to give the sedative that has a minimum of cardiac depression, to avoid acetanilid and depend on bromides and salicylates.

These are the cases where elimination of toxins can be promoted by drinking enormous quantities of water, hot water. Here the old-fashioned ginger and catnip teas shine, all kinds of teas, such as we have seen and heard of in our youthful days from bone-set to sheep-sorrel.

These two other cases where the modern internist becomes a water doctor and recommends hydro-therapy as a tonic.

I have recently seen many types of nervous involvment in grippe, severe cases of neurities involving different nerves; sciatica, optic neuritis with iritis.

Involving different nerves: one eighteen-year-old girl had herpes on the gluteal region, one man had herpes on the wrist and forefinger, one intercostal. All very painful. The girl had agonizing pain and required an opiate. I now have a case of hemiplegia that followed grippe; right arm and leg paralyzed and right side of face. Great difficulty in articulating. She had the chill and febrile symptoms of grippe but not the catarrhal symptoms.

Not since 1892 have I seen insanity precipitated by grippe until this year, when a robust man who had had syphilis some years ago, after a mild type of influenza became dangerously insane and is now in an asylum.

Cases of grippe that we choose to class as febrile types, cases where we have a remittent type of fever, are not always easy to differentiate. These remitting fevers we may mix up with malaria and with typhoid, specially with typhoid if we overlook the associated pericarditis or myocarditis, tachycardia or bradycardia, these are due to nerve involvements, but we do have myocarditis in grippe. I especially remember one case I had where the young man was months getting well, who would faint if raised up in the bed and whose heart was so feeble that his life was despaired of but who finally made it over.

These general infections may also give us abdominal symptoms of typhoid, enlarged spleen, even a peritonitis, and if you will pardon the suggestion I am inclined to be sure that even the abdominal surgeon often gets a whack at our poor little appendix on account of grippe. Therapeutically, grippe is accommodating. We can find symptoms to justify a large use of drugs.

For myself I shall say that I depend on salicylates for the neuralgia, aspirin ofr neuritis.

I believe quinine does good in moderate doses for acute cases and that arsenic is a splendid prophylactic and an ideal tonic for convalescence, especially, in adults.

Finally allow me to say that I do not believe any of us know what grippe is or where the devil it comes from.

*NOMA.

T. F. CLAY M.D.,
TUTWILER.

Noma, cancrum oris, cancer aquaticus or stomatitis gangrenosa as it is sometimes termed, is a rapidly spreading gangrene, usually of moist variety, now generally conceded to be of microbic origin. No specific germ has been credited with the production of this trouble; though many believe a species of leptothrix guilty.

Noma is a rare condition (Keen quotes that in thirteen thousand patients admitted to the Hospital for Sick Children in London only six cases occurred) but one that has long been known and was first described by Battus of Amsterdam. In 1676 Wiseman mentioned noma as "a deep ulcer that eats and spreads without tumor, but hath a rottenness and putrefaction joined with it." Van Swieten, in 1699, first recognized it as a gangrene.

It is a disease of child-life, most frequently met with between the ages of two and five years and is almost unknown in sucklings or after fifteen years of age. It is more common in female than male children and more prevalent in Europe than any country. This disease usually comes up as a complication or sign of some debilitating disease, more than half of the cases following or complicating measles. The three cases I have observed were about the time of desquamation in scarlet fever. Bad hygienic surroundings and poor nourishment are surely factors, since they tend to lower vitality and tissue resistance. As stated, it is thought to be of microbic origin, most likely a leptothrix. Some claim it to be of nerve origin. Fisher takes Magendie's experiments as proof: division of the trifacial in dogs caused destruction of the corresponding eyeball and one-half of the tongue became dry, brown, and fissured, the gums spongy and hemorrhagic, and the teeth loose. "In animals

* Read before the Clarksdale and Six Counties Medical Society.

tenacious of life—the batrachians, for example—that soft parts of the face are cast off in shreds, just as in spontaneous gangrene, after three or four weeks only one-half of the face remains." It does not seem possible that it could be the fault of the arteries, when we consider the blood supply of the cheek; the most frequent location.

The cheek is by far the most frequent site of involvement; most usually unilateral. Some claim the left cheek is effected more frequently than the right. In females the vulva comes next in frequency of predilection. It has been known to occur on the skin of the extremities.

The child is fretful and irritable from the first. If beginning in the cheek, our attention is usually attracted by the child's complaining when masticating food and the presence of a very foul breath. There is soon an excessive secretion from the mouth, which secretion is early fetid and acrid. The process spreads rapidly and we have infiltration of the cheek and hypertrophy of the submaxillary gland. Later the cervical glands are enlarged. Upon examination we find a dense infiltration of the cheek which is not very sensitive and which yields, upon pressure, a dirty, fetid, acrid fluid; there is usually a stomatitis present and a dirty grey centered ulcer of the cheek with mottled purpuric margins. Tumefaction increases and soon the skin of the cheek becomes glazed red and rapidly becomes dusky, then mottled, and rapidly grows darker. A bleb usually forms and soon the ulceration has penetrated the cheek leaving a dirty, punched-out, sloughing hole with cyanotic splotchy areola, yielding a most fetid, acrid secretion. The secretion contains shreds of broken-down tissues, red and white cells and numerous microorganisms. The swelling may close the eye of the effected side. There is apt to be involvement of the alveolar process, not infrequently an osteoperiostitis or even a true involvement of the maxilla, with destruction of bone.

The rapid progress of the ulceration, swelling and sloughing is the same in case of involvement of the vulva. This is, however, more painful, as a rule, owing to early involvement of the urethra and often causing a retention of urine. The retention of urine is brought about by infiltration and occlusion of the urethra or by extreme pain. The process has been known to eat out all tissue of the vulvar ring, even to the recto-vaginal commissure, or expose the bones of the pelvis.

The child is a sick one early, regardless of the location of the lesion. The general symptoms are those of sepsis; tempera-

ture, usually high at the beginning, soon falls to normal or subnormal, in bad cases; pulse is weak and early rapid; there is loss of appetite and weight; not infrequently the mental condition is that of typhoid, though usually clear.

These children often have enteric symptoms, so be careful in your use of purgatives. Patches of broncho-pneumonia or infiltration of gangrenous areas of lungs are not uncommon and most usually prove fatal.

The mortality is very high because of the lowered vitality and rapid progress with prostration; seventy-five per cent. and more usually succumbing in two weeks. This can be decreased if the trouble is early diagnosed and proper treatment instituted.

The best and surest treatment in all things is prevention. Every case of infectious or any other debilitating disease should have its mouth and throat kept as clean as possible. I realize that there are a few cases that develop in children of good hygienic surroundings, etcetera, and with but little or no cause for the development of noma. Of course we are not held accounted for this development. The disease once developed requires prompt and efficient treatment. First let me urge that every ulcer coming in or following any of the debilitating diseases be treated by thoroughly cleaning its surface and cauterizing with phenol or silver nitrate, following the first by alcohol and the latter with saline; using diluted peroxide of hydrogen, fresh, several times daily as a mouth wash. The modern active treatment of noma is to destroy all necrotic tissue and the use of mild antiseptics. Some prefer extirpation with knife and the use of the hot iron later, or even the chemical cauteries, nitric acid, phenol or silver nitrate. I prefer the actual cautery followed by frequent use of twenty-five per cent. solution of hydrogen peroxide.

Be sure to remove all necrotic tissue, even the loose teeth or diseased bone. Ten per cent. ichthyol in lanolin is highly recommended by some. I cannot see why tincture of iodine should not be of value and have no doubt but that I will use it if I ever have the chance.

Sustain vitality by giving easily assimilable liquid diet and use iron—strychnine and brandy probably are the best stimulants to hold our patient up.

*THE HYPODERMATIC ADMINISTRATION OF QUININE; ITS INDICATIONS AND CONTRA-INDICATIONS.

WM. B. HARRISON M.D.,
MATTSON.

At the outset, I desire to explain that, strictly speaking, the title of this paper is a misnomer.

When we speak of administering a drug hypodermically, we think of placing the drug, in solution, in the loose subcutaneous tissue. In the case of quinine, this should never be done. The proper method, as we all know, is to inject the solution deep into the muscles, the gluteal group usually being the site of election.

In the intra-muscular method, we have in one the most effectual and the most disagreeable means of exhibiting this agent.

This being the case, the question of its indication or contra-indication becomes food for thought.

As to whether quinine should be given by the needle or otherwise is determined largely by the seriousness of the case, for this procedure has its particular field in those cases of malaria of sufficient gravity to be designated "pernicious."

It may not be amiss, just at this point, to consider some of the advantages and disadvantages of this means.

Among the advantages may be considered:

First, certainty of absorption. When the drug is placed in dilute solution, deep into muscular tissue, we are reasonably sure that a more or less definite proportion of it will be taken up by the body fluids and so render the blood toxic to the plasmodium.

Second, not having it come in contact with the mucosa of the alimentary canal, we may eliminate the contingency of disturbed digestion.

Third, the dose given is always retained, which is not the case if exhibited either orally or rectally.

Fourth, it is administered by the physician himself. There is no chance that careless attendants may neglect the proper giving of the medicine, nor is there the possibility that a refractory patient may conceal his capsules under the pillow or elsewhere.

First among the disadvantages may be mentioned pain.

This is much greater than that experienced by those taking any ordinary hypodermic injection, save possibly that of some

*Read before the Clarksdale and Six Counties Medical Society.

of the organic preparations, as ergot, and is usually greater than that caused by the injection of sera. It remains a bugbear to all who have once had quinine given in this way.

Second, bad sequelæ of a local nature.

Every physician of experience knows that there occasionally occur abscesses ,ulcerations, necroses and painful nodes at the site of injection, though the greatest care may be exercised in the technic of administration. These dangers may be greatly lessened, though not entirely obviated, by a close observance of the triple rule laid down by Deaderick, which is:

First, absolute cleanliness in all details of technic.

Second, the use of a dilute solution.

Third, the injection of the solution deep into muscular tissues.

Non-absorption of the drug is sometimes complained of, but is due to either faulty technic or the fact that in pernicious malaria, of the extreme algid type, the circulation may be so poor as to not take the solution up.

This brings us to our last objection, which is danger of tetanus. This was much greater in pre-antiseptic days than now, but is to be borne in mind, always.

With this introduction, we may proceed to a discussion of the subject proper.

Chief among the indications for this procedure may be mentioned pernicious malaria of all types. In this condition the needle should almost always be used.

Pernicious malaria is defined by Deaderick as "that form of malaria, extremely acute, which, independently of complications, endangers life in a few hours or a few day." It is readily seen from this that it is a condition which will not admit of dilly-dallying. The specific should be administered immediately in such a way as to bring the system directly and certainly under its influence, namely, by intra-muscular injection. If the condition be extreme, it may be advisable to place the solution directly into a vein. It is said that when so given, one gramme of the drug makes a 1-5000 solution in the blood, which is deemed of sufficient strength to kill protozoa. So far as the elements of time and completeness of absorption are concerned, this appears to be the only way in which oral administration may be improved upon, for it has been demonstrated that the drug will appear in the excretion from the kidneys fully as quickly after administration by the mouth as when given intra-muscularly, and that more than double proportion

of the dose is absorbed from the alimentary tract than from the muscular tissue. In pernicious malaria, however, it is rare that the patient is both able to swallow and to retain the drug, and to have it absorbed from the alimentary mucosa.

Second among the indications for the use of the syringe may be mentioned those cases where disturbances of digestion exist rendering it impracticable to give the agent by mouth.

Third, chronic malaria of stubborn type which refuses to yield to treatment orally administered.

Fourth, cases in which there is a large amount of bile in the stomach and small intestine, rendering absorption uncertain. In this class are those cases in which considerable bile is present, seen too late to cleanse the system by proper purgation, before beginning quinine prophylaxis of the oncoming paroxysm.

Fifth, cases in which there is intolerance established by the long continued administration of quinine prophylactically.

Sixth may be mentioned the use of a solution of the hydrochloride of quinine and urea in minor surgery for the production of local anæsthesia. This we will not pause to discuss.

We will consider briefly the following contra-indications:

First, cases of simple malaria; cases in which the end does not justify the means. It is not desirable that we march forth with our syringes cocked and primed, ready to torture any poor victim of a chill, any more than it is desirable to perform a laparotomy in every case of colic. Lest I be misunderstood, I wish to say that I consider no case of malaria a trivial matter. It makes no difference how benign it may appear, it should receive treatment prompt and heroic. These cases, however, may be treated quite satisfactorily orally.

Second may be mentioned septic conditions of all kinds. In patients in which there is any tendency to furnucles or in which there is any septicæmia or pyemia, are admirable conditions for abscess formation at the site of injection.

Third, any decided tendency to ulceration on the part of the patient is to be considered a contra-indication.

Fourth, and last, quinine should rarely be given in this way to very young children.

After all has been said, the question as to the mode of administration in any given case resolves itself into the question: is this patient in a condition sufficiently serious to justify the pain and danger of bad after-effects incident to the use of the hypodermic syringe.

PELLAGRA INDUCED IN A MONKEY.—PRELIMINARY REPORT.

W. A. DEARMAN M.D.,
LONG BEACH.

Gentlemen—I beg to report to you to-day, that I have been able to induce a typical case of pellagra in a monkey, and have here for your kind consideration the monkey showing indisputable evidences of the diseases. This is a black Honduranian monkey, about nine months old.

You will observe the scaling on dorsi of hands, being symmetrical and extending from the tips of the fingers to the wrists and involving a part of the lower portion of the forearms. The hands are denuded of epithelium and of hair in places. The root of the tail is also in a state of desquamation and shows marked signs of erythema; the tail, as well, from the root to the tip shows marked evidences of desquamation and the hair is coming off, leaving it denuded and rough; the elbows show well-marked evidences of irritation and scaling, which is very conspicuous at a glance, and the tongue is glazed and the mouth seems to be irritated.

Coincident with the clinical signs of the disease you will note the extreme emaciation and prostration of the animal.

This monkey developed a very intractable diarrhœa on Jan. 22nd. 1913, which lasted for several days, the stools were very offensive and numbered about six to eight daily, as best I could observe. In the house where she is kept there are signs up to the present time, where feces were excreted on the wall and other parts of the structure; there has been almost complete anorexia from the time of onset up to the present time; bananas, applies and peanuts, of which the diet heretofore consisted, have been obstinately refused.

Shortly following the first manifestations of the disease there were extreme prostration and progressive emaciation.

A few days following, the signs of desquamation appeared as I have already described in the outset.

Only one day have I observed any marked signs of irritation of the mouth and tongue and this consisted in the tongue being protruded at frequent intervals as if trying to cool it, as an individual would do who had scalded the tongue; this manifestation was also observed by one of the members of the Society, Dr. Williams, our secretary, who is now present.

*Read before the Harrison County Medical Society.

I will in another contribution give a full report of my experiments, which will I hope throw some further light on the probable etiology of the disease.

*WHAT SHALL WE WRITE?

H. C. BUCK M.D.,
FRIARS POINT.

What shall we write that will be of interest, or that will in any way, help any member of our profession, or advance the interest in and general welfare of our profession?

Recently I read in a medical journal an article, the title of which was "How To Write," in which the writer said: "There are oceans of stuff printed in medical journals and books that merely adds to the bulk, and increases the work of the editor, without adding any useful thing to the profession's stock of knowledge." All of us, who read current medical literature, cannot fail to be impressed with the very large number of such papers published, papers that are seemingly written that the writer may display his knowledge, and that are absolutely impractical and useless to those of us who compose the rank and file of the profession. I frankly confess that such ultra-scientific papers are to me but as 'a sounding brass and tinkling cymbal,' and I believe that a very large per cent. of my fellow practitioners will agree with me. Again I quote from the article mentioned above; the writer says: "We are deluged with articles voicing just one idea, 'Send me your patients.' Others are compiled from the works of standard authors, that are accessible to every doctor who reads." While I do not believe this charge can be brought against those who read papers before this society, I think we may all profit by the criticism.

In the Bible we can read that, on one occasion, the Angel of the Lord appeared to Saint John in a vision, or dream, and said unto him: "Write the things which thou hast seen, and the things which are." Regularly, twice a year, our secretary appears to me, (not in a vision or dream), but by letter or postal card, and says to me: "Write." He is not as kind to me as was the angel to Saint John in that he does not tell me what to write, but leaves me to solve the question unaided. I am free to confess that I have found the solution very difficult.

We meet here twice a year, for what purpose? The purposes of this society are enumerated in the constitution. Among

*Read before the Clarksdale and Six Counties Medical Society

other things the constitution says "That by frequent meetings, and full and frank interchange of views, they may secure such intelligent unity and harmony in every phase of their labor, as will elevate and make effective the opinions of the profession in all scientific, legislative, public health and social affairs, etc." I would suggest that, to the other purposes of this society we add, "And exchange our personal and individual experiences at the bedside of the sick and afflicted." Why? Because history teaches us that, since the profession of medicine has been known, it has only been advanced and elevated by the personal and individual experiences—and often the life sacrifice—of the members of the profession.

How did the profession, and the world, learn the role played by the mosquito in the spreading of yellow fever and malaria? Only through and from the personal experience, and life sacrifice, of a few brave members of our profession.

While we know that men and women are all created after the same plan or model, that each sex possesses the same organs, created for the same purposes, and possessing the same functions, we soon learn there are differences, learn there are individual characteristics, differences in the development of the different organs, also different mental characteristics, so that no two individuals are exactly alike. Hence I would suggest that we study our cases, but more especially our patients, and note any peculiarities, and, when we find anything unusual write it down and report it, so that all of us may share the knowledge and profit by the experience. If we do this we will each and all be benefitted, and often some one of us get help over difficulties that, without this help, would have perhaps been insurmountable. For example, many of us know that during the past few months this beautiful little city of Clarksdale was afflicted with quite a number of cases of typhoid fever. While the prominent symptoms in each of these cases were so nearly the same that a diagnosis of typhoid was justifiable, I venture the assertion that the physicians treating these cases found no two of them exactly alike, that they found in each case some peculiarity not found in others, and which often forced them in some particular to change the routine of their treatment.

These are the things of which we should write; in other words, write of the things we have seen, give our individual experience, always striving, and hoping, that we may write something that will help our brother physicians.

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OFFICIAL ORGAN OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION AND ITS COMPONENT SOCIETIES.

SUBSCRIPTION ONE DOLLAR PER ANNUM.

Anent fee-splitting the *Journal of the Indiana State Medical Association,* January issue, gives us the following:

"In Governor Marshall's message to the present Indiana Legislature the subject of fee division among physicians has been given official attention. Governor Marshall says: 'In the interest of high professional training I recommend that the act creating the Board of Medical Registration and Examination be amended so as to require the board to revoke the license of a physician who splits his fee with an expert physician or surgeon.'

"This is a blow at the fee dividers or the commission evil, and it is a merited rebuke. It is unfortunate that a high sense of honor among members of the medical profession has not put an end to such a degrading practice as fee dividing, and though every right-thinking physician will welcome legislation which makes it a legally punishable offense to divide fees, yet it is a source of regret that the subject had to come in for attention at the hands of our governor with the recommendation that fee division be under legislative control."

This throws new light on the subject and makes it appear even more awful. We understood that it was the specialist's fee that was split and didn't feel so bad about it, but evidently they do things differently in Indiana—or else the honorable governor and the erudite editor are clinging to the ears of the wrong sow.

The customary phase of it is outlined in the following letter which was sent us by Dr. C. O. Buck of Friars Point, who is always alive to everything that is going on in the medical world. This letter was received by him recently and he writes that two other Friars Point physicians received the same communication. The italics are ours.

Memphis, Tenn., January 18th. 1913.

DEAR DOCTOR:

Pardon me for the liberty I am taking in addressing you, but I wish to attract your attention to a matter that I am sure will be of vital interest to both of us.

I am specializing in the treatment of *"Skin Diseases"* such as cancers, tumors, wens, cysts, keloid, enlarged glands, *goiters*, eczema, lupus or tubercular conditions, etc., and am well equipped with all the latest improvements and methods of treatment known to medical science, such as X-Ray, vibrators, leucodescent lamp, therapeutic lights and all the latest medical treatments, etc., and am connected with a private Hospital or Sanitarium, where I have *one of the best surgeons in Memphis* to do the surgical work, and I am sure our patients do, and shall receive all the comforts of modern conveniences and surroundings *possible*.

I was associated in the early part of my professional life with one of the most *prominent Physicians in the country*, who had taken instruction in Berlin, and other noted critics, and I am sure *I am a squalified to follow the said chosen line of work as anyone in the city*, from the standpoint of producing results.

Now Doctor, if you have any patients afflicted in my line of work and are not in a position to properly care for them on account of Hospital *inconveniences;* or the fact that you cannot afford to equip yourself with all the modern methods used, for the limited number of cases that may come under your care, I am submitting a proposition, that you send or bring these cases to me, and if we arrange to treat them, *I will divide the professional fee with you*, less Hospital expense, medicine charges, etc.

I believe you will agree with me that I will be able to give the cases better attention, and *can no doubt get larger fees for your part of the work*, than you could possibly get at your office, and *I assume all the risk and responsibility, and relieve you of all cares connected with such cases.*

I am operating strictly *in an ethical way*, and I assure you one trip to my office will convince you I am prepared to produce the best possible results.

Thanking you in advance for any favors shown me and that I may be able to meet you personally,

I beg to remain.

Yours fraternally,

H. A. McLAUGHLIN M.D.

Wishing to learn something of Dr. McLaughlin's status, a letter was sent Dr. Wm. Krauss in Memphis, asking if the gentleman's name were on the roll of the Memphis and Shelby County Medical Society. The reply is too personal to be quoted in full, but the significant paragraph runs as follows:

"I am in position to state that Dr. H. A. McLaughlin, 32 Southern Express Building, is not a member of the Memphis and Shelby County Medical Society, and his right to practice medicine is being investigated by the State Board of Medical Examiners. Thank you all the same for calling my attention to this ethical fee-splitting gentleman."

Judging from this, we feel that Dr. McLaughlin will not be in a position to split many fees with anybody, but we would dearly like to know the name of the "one of the best surgeons in Memphis" who does his surgical work. Either Memphis has some "mute, inglorious Milton" in its midst, or the street cleaning department should be invoked.

For some time we have been watching the rapid growth of the Southern Medical Association and wondering what would be the outcome. Originally constituted of a few of the members of the state associations in half a dozen southern states, it has spread over sixteen states and while we cannot give the membership we are advised that it has grown correspondingly. The latest indication of this growth is seen in a letter from Dr. C. A. Rhodes of Atlanta, who is trying to arouse enough interest in pediatrics to get that branch recognition as a special section. This is the entering wedge and with a little more growth the association will be split up as badly as the A. M. A., where the general practitioner, who wants a full meal, has to spend his time trotting from section to section, wasting time and generally managing to miss those papers he wants most to hear. The vast majority of the members of the S. M. A. want pediatrics; they need it; but to do them any good it must be put in the section on general medicine, where they can get it, and not stuck away in a separate building, at hours that conflict with the work of the section on medicine. Separate sections for the surgeons and the men doing eye, ear, nose and throat work are right and proper, especially the latter, but pediatrics is too surely the work of the general practitioner, at least in small towns, and there are but few out of that class in the south, for him to be deprived of the benefits of the papers on this subject that may read before the Association. Dr. Rhodes is our authority for the statement that Dr. Harris, the secretary of the Association, favors the plan or at least considers it practicable. Naturally the officers want to see the Association bulk as large as possible. The state associations, on the other hand, should see that it doesn't get too big to be a menace. With the present plan of taking in anybody and everybody, regardless of his state affiliation, the time may not be long coming when the state organizations will find that they have built up an "old man of the sea" who will sap their vitality and do them no little damage.

Medical Defense.

Clarksdale, Miss., Feb. 15th. 1913.

Dr. E. F. Howard,

Vicksburg, Miss:

Dear Doctor—In view of the fact that the "Medical Defense" feature of our State Association is likely to come up for

final settlement at the next meeting, I have written to the secretaries in those States where the defense feature is a part of the constitution or by-laws. I think the readers of our valued journal will be interested in the information contained in the replies. I know you could not give space to them all, so I am inclosing excerpts from a few, which I hope you can publish in your March number.

In my letter of inquiry, I stated that there was an inclination among some members in Mississippi to repeal the defense section.

Without exception, all the replies (thirteen received so far) protest that such action would be extremely unwise.

Very sincerely,

JAMES W. GRAY.

"As you have adopted the defense against malpractice, for goodness sake do not permit them to repeal it. In my opinion it is one of the pillars of the Association. Kentucky has been looking after these suits for the past four years, and our success has been wonderful.

"Some day they are going to begin to sue the Mississippi doctors and you will need two defense committees. All States have work to do and if your defense committee is lucky enough to escape, for goodness sake don't lose your luck stone."

JOHN P. MOREN M.D.,
Chairman of the Medico-Legal Committee, Kentucky State Medical Association.

"Curiously enough we too had no cases to start with, but since we have had, perhaps over thirty, many of which have not come to trial. All we have had have been settled in a satisfactory manner to us, and most of them have been won in court and some of the cases before juries. Our members regard this as one of the most valuable features offered, and should any one suggest abolishing it, it would meet with strong protest. Our attorney has had considerable success in handling the cases and many that have been threatened have not actually come to trial. I should strongly urge you to continue your defense feature for I am sure it is very much worth while."

JOHN RUHRAH M.D.,
Secretary of the Maryland Medical Association.

"It would be difficult to have any one of this State to un-

derstand how a movement could possibly succeed to repeal the Medical Defense proposition."

A. T. McCormack M.D.,
Secretary Kentucky State Medical Association.

"I trust that you will continue your efforts to employ your own attorney in one or two cases. If well fought such an experience ought to convince the members of your society of the great value of this feature of protection."

Arthur J. Patek M.D.,
141 Wisconsin Street, Milwaukee.

"We have a Defense Fund department and think it a splendid feature of our work."

Joseph M. Atkins M.D.,
Secretary of the Nebraska State Medical Association.

"I have found that there flows from the defense feature, in addition to the actual protection it affords our members, a strong and definite growth and perpetuation of the spirit of fellowship and protection of the welfare of each other among our members such as never existed previous to the adoption of this measure.

"You are fortunate in not having had suits thus far. But that fact does not guarantee that your members will remain immune in the future. By all means, your Association should continue this benefit of membership and your Society every year should set aside a certain sum for the fund."

E. J. Goodwin M.D.,
Secretary-Editor Missouri State Medical Association.

"The defense feature in our Association has proven very satisfactory."

Thos. McDavitt M.D.,
Secretary Minnesota State Medical Association.

"I think that your Association would make a great mistake in giving up the defense of malpractice suits. The fact that you have not had a suit in the last year is a source of great congratulation. I sincerely trust that you may never have one, but I do not see how you can go very much longer without having someone sued unless the doctors in Mississippi are very different from those of the other parts of the United States, and I have had some good friends in Mississippi, and

they are equally good fellows with the doctors elsewhere who are being sued.

"I may cite a case that had just been decided in Ogdensburg. Two physicians and two bishops were sued for illegally declaring a priest insane. The suit was for $100,000. The court decided the doctors were innocent and mulcted the bishops for $15,000. Whether they will get off on an appeal I do not know, but the two members of our Society were exonerated. I do not hesitate to say that this trial, which cost the State Society a considerable amount of money, as the attorney's expenses, railroad fare, hotel bills, etc., were over $200, has materially strengthened the State Society in that neighborhood. I also do not hesitate to say that it has saved the doctors at least $1,500 which they would have paid out for attorney's fees. It was a long, complicated, arduous case, and but for the skillful work of an attorney trained in this business, the doctors might have been included in this verdict."

Wisner R. Townsend M.D.,
Medical Society of the State of New York.

"We feel that it has been of great service and even though we are compelled to raise the cost per member still higher, the majority are in favor of continuing the plan."

V. L. Treynor M.D.,
First Vice-President Iowa State Medical Society.

"I have only praise to give to the plan, which has proven one of the strongest features in our Society. The opposition which first existed in some localities, has almost entirely disappeared, and the whole Society (1700) members, is supporting the plan. Cordially hoping you will retain it.

Charles S. Sheldon M.D.,
Secretary of the State Medical Society of Wisconsin.

Society Proceedings.

Forrest County Medical Society has elected officers for 1913 as follows: C. C. Hightower, president; R. M. Donald, vice-president; W. R. Bethea, secretary-treasurer; J. J. Stevens, delegate.

The second meeting of this year was held on the night of Feb. 6th., a large percentage of the twenty-four enrolled mem-

bers being present. Dr. J. J. Stevens read a paper on "La Grippe," and Dr. R. M. Donald one on "Broncho-Pneumonia," both being freely discussed and much interest being manifested.

The coming year promises to be a very interesting and profitable one with our Society.

C. C. Hightower.

Lauderdale County Medical Society being aroused by statement made in the public press and other sources relative to the Mississippi State Board of Health issuing license to applicant who had not made required grade at meeting of examining board in October 1912 and other matters, deemed it necessary and not reprehensible to the medical profession at large in the State of Mississippi and called a special meeting Jan. 24th. 1913, 8 p. m., to investigate and elicit facts as best they could concerning conditions prevailing or rumored as prevailing in the State Board of Health.

Dr. Reynolds, member of the Board of Health, was present and made statement as to his opinion of status of things in said Board. There was quite a discussion concerning above stated rumors, and further investigation or more information being desired, the Society authorized that a letter be written to each member of the Board of Health, who was not present at this meeting, respectfully asking them for a written statement of their knowledge and opinion of the conditions which prevail in the Board, or if possible, to attend, was given a most cordial invitation to be present at the next meeting (Feb. 13th. 1913) that they as members of the Lauderdale County Medical Society and of the Mississippi Medical Association, might endorse or condemn any conditions which would be for the upbuilding of the medical profession in this State.

This step was not intended to censure any members of the Board unjustly, but to know true facts of the case.

Regular meeting of the Lauderdale County Medical Society met in Board of Trade building Feb. 13th. 1913, with good attendance—at which time, communications were read from different members of State Board of Health who replied to request made them as result of special meeting in January.

Dr. I. W. Cooper of Newton, Miss., was present and made statement concerning conditions which prevailed in State Board of Health from the opinion of the minority, or the five members who were elected by the State Medical Association. This statement brought forth quite a discussion among the members of the Society. In addition to these statements and

discussion—which was brought forth from it by different members, there were some interesting clinical cases reported.

G. F. Douglas.

Tri-County (Tate, Panola, DeSoto)—At a meeting of the physicians of Tate, Panola and DeSoto counties held at Senatobia Feb. 5th., a Tri-County Society was organized consisting of members of the county societies of the above named counties. This will not affect the county societies as such, but it will give a larger attendance at each meeting and make them more effective. The following officers were elected: president, M. C. Ellis, Senatobia; vice-presidents, R. A. McReynolds, Strayhorn, G. H. Wood, Batesville, L. H. Brevard, Eudora; secretary and treasurer, D. C. La Verne, Senatobia; councilors, Anderson and Miller, Panola; Weissinger and Miller, DeSoto, Wilson and Smith, Tate.

D. C. La Verne.

Tri-County (Pike-Lincoln-Copiah) met in regular bimonthly meeting at Brookhaven, Feb. 18th., with following members present: Drs. Arrington, Beacham, Butler, Catchings, Dickerson, Flowers, Frizell, D. W. Magee, Higdon, D. W. Jones, R. E. Jones, Johnson, Little, D. W. Magee, T. K. Magee, McLeod, McRee, Moore, Purser, J. A. Rowan. Dr. Arrington opened the program with a paper on Serums and Bacterins; Dr. Dickerson followed with a paper on Diphtheria; and Dr. Frizell came next with one on Meningitis. Discussion was withheld until all the papers had been presented. Then a general discussion of the subject of serums and bacterins, and their application followed, in which practically every member took part. The discussion showed our fellows to be right up-to-date on recent literature. One of the best features of this Society is the fact that practically every man feels himself competent to discuss any subject that comes up, and no paper ever falls flat for want of discussion. In the seven years of its existence, it has never failed to carry out the scientific program originally laid out for that meeting.

D. W. Jones.

DR. S. WADE GLASS
President

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*VENEREAL PROPHYLAXIS.

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Venereal disease is threefold: gonorrhœa, syphilis and the nonsystemic chancre, or chancroid. The former two are so far-reaching in their evil effects that it behooves us all to take serious thought as to what we can and will do towards the extinguishment, or at least the abatement of these evils. The last named form, while not so serious, should not remain out of consideration.

Of gonorrhœa, Noeggerath writes: "I have undertaken to show that the wife of every husband who, at any time of his life before marriage has contracted a gonorrhœa, with very few exceptions, is afflicted with latent gonorrhœa, which, sooner or later, brings its existence into view through some one of these forms of disease: perimetric inflammations, both acute and chronic, ovaritis, salpingitis and catarrh of the genital tract." He continues: "I believe I do not go too far when I assert that of every one hundred wives who marry husbands who have previously had gonorrhœa, scarcely ten remain healthy; the rest suffer from *it* or some other of the diseases consequent thereto. And of the ten that apparently are spared, we can positively affirm that in some of them, through some accidental cause, the hidden mischief will sooner or later develop itself."

This does not include its evil effects on the male subject, such as a chronic gleet, urethral structure, gonorrhœal arthritis and others; involving destruction of the vas deferens, rendering him sterile without his going to the trouble of submitting to the operation of vasectomy.

Syphilis by some very eminent authorities is adjudged to be a self-limited disease, and by our more numerous friends said to be curable by mercury and by iodine; gonorrhœa, by some, to be as easily cured as a bad cold and chancroid speed-

*Read before the Clarksdale and Six Counties Medical Society.

ily cured by complete cauterization of *all* the diseased part. Supposing that these three diseases are *so* amenable to treatment, how many of these *are* cured? The victim applies to his physician; treatment is instituted, the proper lessons are given and gratefully received; promises of compliance are made, but for some cause or other he does not get well. His promises are "made to the ear and broken to the hope." The syphilitic *forgets* to keep up the treatment and does not forget to continue in his evil ways until, as a general result, eighteen per cent. of the people are syphilized. (Hyde.) The gonorrhœic sets aside his drugs, has not set aside his dram, and neither he nor the syphilitic discontinues congress with the opposite sex, so notwithstanding doctors and drugs and "many lengthened kind advisers," the evil lasts. The easy communicability of the chancroid is its element of mischief against which we have to guard.

Fournier counsels that "a syphilitic should wait three or four years at least before contracting marriage and that short of this minimum there is everything to fear; and during the period in question the curative influence of a systematic, methodic and prolonged treatment shall be added to the corrective influence of time. This also presupposes a total abstinence from "wine and women."

In addition to the old-time antisyphilitics, we now have a class with arsenical base; atoxyl, arsacetine, hectine, etc., these all precursors of salvarsan. Of this last a dose of three-tenths to five-tenths is given either by intravenous or intramuscular injection—the full dose contains three grains of arsenic.

The results of this treatment have been brilliant in the rapid disappearance of all signs of syphilis, even to the extent of rendering the Wasserman reaction negative, but what is "the latter state of that man?" Is he cured and has he been rendered immune?

Likely, the subject of this cure (?) will "sin again to be again forgiven." We have no guarantee of his cure, nor of his subsequent good behavior; so of the gonorrhœic whom the disease has sterilized; this one is the greater menace of the two in that he can persuade his victim that no baby can come of their commerce.

Leaving the work of research and application to our eminent brethren, let *us* apply ourselves to the work of influencing the subjects of these terrible ills, present and prospective, so as

to, in our small way, rid them and all others of this monster evil.

The sexual faculty is an attribute of our nature. Its exercise is required for the continued existence of mankind and is legitimately used for this sole purpose, when it is subject to no law but that of temperance.

The divine blessing: "Increase and multiply" expresses the motive of the sexual power and should be our guide in its exercise. When used only *so*, we should have none of the consequents in the form of disease; and to restore the primal condition should be the object of our endeavor. This primary constitution of the family is monogamistic; one woman for one man. As we come down the ages we, to use word of a sacred writer, "left our first faith," and the tyrant man was not content with but one woman, nor the facile woman with but one man. The gratification of the sexual passion, within and without matrimonial limits, was universal.

As told us in sacred and profane history, sexual vice in all its hideous forms, was spread over the whole earth; and had it not been for the execution of the divine commission given nineteen centuries ago, the race would, likely, by this time have gone far toward extinction.

This vice which was controlled, as far as it could have been in free will agents, by the moral force of Christian discipline, so to say, restored the sexual function to its original intent and so it remained until in later days came a loosening of the moral sense; illustrated bythe author of "Table Talk" in this couplet:

"Wehr liebt nicht Weibes, Wein und Gesang
Er steht ein Narr sein Leben lang."

The sacredness of the vinculum is disregarded, the courts separate married people for any or almost no cause, in utter disregard of the welfare of the offspring, and in direct opposition to the divine law.

What is the remedy?

Here comes first the function and the duty of those to whom the Redeemer said: "Teach them to observe all things, whatever I have commanded you." * * * * * "All days until the consummation of the world."

Let us, co-operating with those so commissioned, so recreate the moral sense, demonstrate to all, particularly the young, by word and example the beauty of chastity; and warn them of the evil of the opposite vice, not merely this but vice in all its form; all links in one chain of evil.

Let us so supervise the growth and nurture of the souls of

our children—given to us by the Divine blessing to train in the ways of goodness and truth. Let us guard them against contamination from servants, schoolmates and all others and so train them that in the end no regrets will remain to us and that each of us may joyfully repeat: "Of these whom Thou hast given to me I have not lost one."

Let us, ourselves, so live that we give this vice, in all its forms, the vade retro. This is possible, otherwise the law would not have been made.

Having, ourselves, attained to this, we shall be prepared, in loving sympathy to consider and apply remedies to the evil existing conditions, the most prominent of which is harlotry.

How are the ranks of harlotry supplied?

The sexual instinct, if I may use the term, is common to man and woman, displaying itself in different degrees in each, but most aggressively shown in the man. According to the strength of his advance and the weakness of the woman is the success of his overtures; he gains his point, he accomplishes his evil work, the woman, either by pregnancy or disease, goes with her shame uncovered, and what is left for her? The scorn of her sister woman, the contempt and neglect of her betrayer, banishment from home and friends, and the only door open to her is one that admits her to a life of sin, unless she chooses to go "anywhere, anywhere, out of the world."

Thus, mainly, are the ranks of harlotry supplied.

She offers her body for abuse and who are her customers? Men!

These are not generally solicited nor enticed to enter these abodes of the wretched. They come of their own free will, young and old, wedded and unwedded. Have I said wedded? *Yes*, I regret to say it. A friend of mine, many years since passed over to the great beyond, after sowing his wild oats, married and mended his ways. When in Memphis one day he was met by one of those women who taxed him with his neglect. He answered: "Sally, I'm married now." Her reply was: "Jim, if we had for customers only unmarried men, we should have to shut up shop." Is this generally true?

Considering, then, the woman in the case and the sad story of her wrongs; as she is the most prominent factor and the chief agent of the inception and spread of venereal disease, what remedy shall we apply and how apply it?

Shall we license harlotry? I say *no;* as we should not license drunkenness nor any other form of sin.

Shall we segregate the unfortunate? To this I say yes,

but the difficulty is that they are not all inmates of public houses; but so far as possible the police should make and keep a record of *all* engaged in harlotry.

Periodical surgical inspection should be made of each and all of such women and when any are found to be diseased in a transmissible form, each should have treatment in a hospital for such patients where they should be subject to influences tending to their reformation.

The record is that ninety per cent. of harlots are subjects of chronic gonorrhœa; some in which the coccus cannot be demonstrated but who sometimes infect a customer; a large number in which it is found and who do not transmit it; many old syphilitics among them, so who is ill or who is well is a riddle hard to read. "Who enters there will leave all hope behind."

The dwellings of these unfortunates should be so thoroughly subject to police surveillance as to enable them to do what should be required of the police as a duty—keep complete records of every visitor, which record should be kept open for public inspection in the office of the chief of police. If we register the poor woman, why not the chief sinner, man. We should not only register him but make his act penal; particularly "when a man's married." The pretext that carnal copulation is requisite for health is false as the source whence it comes, the father of lies.

Venereal prophylaxis is "a vast question almost without a reply," but as with inebriety, so with lechery; if we, ourselves, refrain from promiscuous carnal commerce; if we do our full duty by our neighbors and our children and other dependents, the evils now present in so many human systems will, by the corrective influence of time, die out, setting up that which is eulogized in Holy Writ thus: "How beautiful is a chaste generation with glory." All this will give us as nearly as we can obtain it a venereal prophylaxis.

*SOME EXPERIENCES WITH PELLAGRA.

GEO. M. SHAW M.D.,
ROBINSONVILLE.

Mr. President and Gentlemen:

I assure you I appreciate the honor conferred on me to read a paper to-day, which is some of my experience with pellagra. It has been rather gloomy for me and more so for a

* Read before the Clarksdale and Six Counties Medical Society.

very large percentage of the patients, as a good number have died. My experience embraces twenty-three cases; beginning July 3rd. 1908, to the present time. My first case, negro man, aged thirty-five, previous history good. I did not know what the trouble was, I told him it was poison oak, as he had been working in the woods. Treated him for poison oak poisoning, but when the skin began to come off in sheets from the back of his hands and forearms and chest, I was wrong, but was at a loss to know what it was as I knew it was something I had never seen before. He seemed to get well when cold weather came. He moved away in January so I do not know how the case terminated. My next case was seen June 4th. 1909, negro man, aged twenty-six, previous history syphilis. I treated him for a month for diarrhœa, nervousness and syphilis, and he grew worse all the time. I concluded I was wrong in my diagnosis and did not know what I was trying to treat, so had him sent to the City Hospital in Memphis. After he had been there about a week they diagnosed it pellagra, and treated him until December and discharged him. He seemed to be well and worked well until July, when all the old symptoms returned in an aggravated form. I had him sent to Vicksburg to the hospital about June 15th. He died in about two weeks. My next case was May 10th. 1010, negro woman, aged twenty-five, mother of baby five months old and nursing; baby seemed perfectly well. I was sent for to see for dysentery. I found all the symptoms of pellagra and treated her accordingly for three weeks, but no improvement. She went to the City Hospital in Memphis and died in about ten days. The baby has never shown any signs of the disease. Next case was seen July 15th, negro girl, aged nineteen. Previous history good. All symptoms well developed. Treated her until cold weather with arsenic, nox vomica and iron, dieted her, had her to take hot bath every day and drink a gallon of water every day. She improved from the first. Put her back on medicines same as first the first of March and continued until September. She seems to be as well as ever now. Next case was seen May 29th. 1911, negro man, aged thirty-one, previous history good. Was sent for to see him for dysentery and treated him for catarrh of bile ducts. He seemed to improve all right until about July 1st., when I was sent for to see him as crazy. I found all the symptoms of pellagra. Had him sent to Vicksburg Hospital next day. He died there in about ten days. I have not sent any more to the hospitals since. It would take too much time to go into detail of the rest of the cases I have had, twenty-three cases since I

saw the first one in 1908. There are nine living, eleven dead and three moved away, I don't know whether living or dead. Was called to see negro woman September 22nd, 1912, and found a family of six, man and his wife and four children, the youngest child was only eight months old. All had well developed cases of pellagra except the baby, which seemed to be in perfect health. I had seen two cases in one family before at the same time but in this one there were five. All are still living and seem all right now. I have only treated one white person and that was in 1912. I first saw him, aged thirty, previous history syphilis. Had been to Hot Springs, Ark., in 1910, and treated with mercury for two months and came home and continued the same. He went back to Hot Springs in the spring of 1911 and took the salvarsan treatment, two intravenous injections, and seemed to be all right until about January 1st, 1912, when he was troubled with a diarrhœa and colicy pains, was sore and there was a good deal of nausea, some vomiting. I treated him along until June, 1912, sometimes better and then get back in same condition. He drank a good deal; I told him I could not do anything for him unless he would quit drinking; he would quit for a while and go at it again. I saw him about the first of June and noticed all the skin lesions of pellagra and then understood the bowel trouble. I had him take three intravenous injections of salvarsan and have had him on arsenic ever since. Have him to leave it off about one week in every six. Has quit drinking and the use of tobacco. He seems to be doing all right now.

My treatment now is to clean up everything around the premises and try to have the patient bathe every day in salt and water and drink as much as a gallon of as good water as can be had. I think the more water they drink the better for them. I want to keep the kidneys as clean as possible. I believe it keeps back the brain lesion to a great extent. I give them as wholesome diet as possible. I stop any food that is made from corn as much as possible. I don't know that the disease is caused by eating the products made from spoiled corn or not, but am inclined to think so. Now for medicine I do not believe in giving very much. I think arsenic is the best we know of yet, although I believe it is right to give opium when needed, also calomel, strychnia and iron. I rely on arsenic in some form and water more than anything. I acknowledge I know but little about the disease, but it is here with us and we will have to keep trying until we do know.

I hope all your experience has been better than mine.

*PNEUMONIA; BRONCHO PNEUMONIA; CAPILLARY BRONCHITIS; LOBULAR PNEUMONIA; CATARRHAL PNEUMONIA.

R. M. DONALD M.D.,
HATTIESBURG.

An inflammation of the terminal bronchioles and air vesicles, catarrhal in type and usually accompanied by inflammation both of the larger tubes and the pleural membrane.

Causes: exposure to changes in temperature and humidity; inhalation of irritating dust, odors, or chemical vapors; inspiration of particles of food, liquid or solid, or of some irritating agent (kerosine oil, small buttons, match sticks or tooth picks for example might become the primary causative factor in the production of a case of broncho-pneumonia.)

In considering the cause of broncho-pneumonia I must stress the existence of a local infection in the lung; while I doubt the probability of infection alone acting as a primary causative agent, believing that the activity of infection is secondary to some condition or accident which lowers local resistance and permits the infecting agent to exert its force on the lung; still it is highly probable that however much we might be exposed to unfavorable conditions of temperature, humidity, odors, etc., or regardless of how we might depreciate the constitutional resistance by indiscretions of diet or habit; were it not for the presence of infection we would not have pneumonia and at the worst it would only result in a fleeting variation from the normal, easily overcome by a few days careful hygienic management.

It is not my purpose to devote much time to the pathology of this condition, but will call attention to at least a few important points.

In lobar pneumonia the involvement is of the lobe or lobes as a whole and the inflammatory debris in the air cells consists of perverted blood elements, viz: red and white cells and fibrin, while at the same time there is practically no involvement of the epithelial membrane lining the air cells.

On the other hand in broncho-pneumonia the involvement is of the lobule and a single lobule may be inflamed in some location and the remaining part of that lobe still continue in a state of practically perfect health so far as appearance and maintenance of function is concerned; furthermore, the debris present in the air cells in this form of lung inflammation has

*Read before the Forrest County Medical Society.

its origin from an active inflammation of the membrane lining the tubes and air cells, hence of necessity consists of pus-cells, broken epithelium, etc., together with myriads of whatever form of germ life may be present.

Symptoms: broncho-pneumonia is a disease of the extremes of age, very young children and extremely old adults most often falling victims to its ravages; this being probably due to the fact that the stroma of the lung has not yet developed in the child and has undergone a process of atrophy in the aged. The onset of the disease may be gradual (taking cold) or almost as sudden as a "bolt from the blue," a child that has been previously well is suddenly seized with convulsions from which with relaxation comes pain, fever, cough, cyanosis, vomiting with either diarrhœa or constipation, etc., finally running the typical course of broncho-pneumonia.

Cyanosis is an important symptom, is due to imperfect oxygenation of the blood from lack of healthy absorbing surface in the lung, may be slight and of but little consequence, or marked and a signal of grave danger unless provision is made for a plentiful supply of oxygen.

Temperature is extremely variable, slight or moderate fever in poorly nourished, delicate subjects; high to extremely high fever in the plethoric being the usual rule.

Cough is usually present though not always a noticeable symptom.

Pain: in certain cases where pain is a marked symptom it frequently occurs that an experienced physician can practically make the diagnosis almost upon the instant of entering the room where the patient is lying by observing the peculiar grunting respiration that is characteristic of pneumonia where pain is a factor.

It might be well to call attention to the fact that so far as symptoms are concerned it were well to remember that there are almost as many pictures of broncho-pneumonia as there are patients to have the disease.

You will often see patients with this disease in whom there is such a predominance of some one single symptom as to almost entirely obscure all others. For instance pain; almost any physician can recall one or more cases of penumonia in older children where the pain was so prominent and reflected as to lead the family to believe that the child had appendicitis and it was only by a most careful examination that the trouble was located in the lung.

Again you may find a child having but slight cough and

fever with severe vomiting and diarrhœa or constipation, tympanites, etc., indicating gastro-intestinal disease, but closer inspection will reveal that the gastro-intestinal symptoms are secondary to and dependent upon an inflammation in the lung.

In plethoric, full-blooded subjects it is usually the case that we find almost if not all the symptoms of marked intensity—a fulminating broncho-pneumonia if you please.

Here we have sudden onset, high fever, rapid respiration, acute pain, marked cough, restlessness, acute constipation or perhaps diarrhœa, etc.

On the other hand there is an asthenic type usually occurring in pale, delicate, poorly nourished patients, where the symptoms are nothing if not atypical. I have treated such cases where the patient would play around the room two-thirds of the time notwithstanding the slight temperature, cough and lassitude that was present; and physical examination of the chest at the same time showed rales, friction sounds, bronchial and broncho-vesicular breathing.

I have chosen to devote more time to the fickleness—if I may use the word—of broncho-pneumonia, than to take up at length the differential diagnosis of this from other conditions with which it might be confused.

I would like to consider now one or two points regarding some possible complications.

First of all, always be on your guard against a possible invasion by the inflammation of the pleural membrane and remember that this may occur and be of so small moment as a slight involvement of an insignificant spot only attended by slight pain and perhaps a friction rub or it may be of such serious character as to result in an empyema with several ounces or even pints of pus, collapse of the lung, and a full train of septic symptoms all fraught with anxiety to you and danger to your patient's life and future well being.

Further; never! never! forget that a middle ear infection is not only possible, but an extremely probable complication. I forgot this once but don't believe I'll ever be guilty of the same offense again. I treated a two-year-old child during an attack of broncho-pneumonia, and as one General Sherman or some other Yankee highcockalorum is alleged to have said: "if my foresight had been as good as my hindsight I would have been better off by a damsight." As a result of my overlooking the middle ear infection my patient had a blood infection, pyæmia, with metastatic abscesses, his life was endangered and con-

valescence prolonged many weeks beyond what should have been but for my lapse of the aforementioned foresight.

The possibility of gastro-intestinal complications has already been mentioned in sufficient length and it may well be remembered.

In considering the treatment of broncho-pneumonia I wish to call your attention to the fact that in practically all cases of this disease where the termination is fatal, death is due either to the extreme degree of intoxication which so overwhelms the vital centers as to destroy all co-ordination of function between the organs of the body, making recovery impossible, or to an acute cardio-vascular insufficiency—an inability of the heart and blood vessels to drive the blood stream through the inflamed lung tissue and thence return it to the distal tissues of the body bearing a sufficient quantity of oxygen for the maintenance of cell nutrition and function.

Hence the first and all-important consideration in the treatment of pneumonia is a bountiful supply of clean fresh air.

Personally if I should ever be so unfortunate as to contract pneumonia again I would infinitely prefer a clapboard shack with cat cracks in the walls, no fire at all, and on top of a hill swept by a forty-mile gale, to the best appointed hospital in the country with all the doors and windows closed.

In the treatment of pneumonia my first thought is air, after provision for which I class my medicinal agents in the order of their importance about as follows: mercury, opium, counter-irritants, alcohol and other nourishing and stimulating agents.

Mercury in the form of calomel—always calomel—first in large doses to clear out the stomach and bowel, stimulate glandular activity and relieve the kidney of all strain possible.

I usually give repeated courses of calomel and about the time I decide that I have given enough, start again and give more; unload the liver and keep it unloaded being my motto.

Opium in the form of Dover's powder relieves or at least allays the pain and by assisting in maintaining the circulatory equilibrium promotes the comfort and well being of the patient, and I have heard "puts the bug to sleep"; however facetious the remark may sound I believe the assertion merits serious consideration.

Counter-irritation may be had by sinapisms around the entire chest followed with antiphlogistine (for which I have but little use) or well rubbed with glycerine and covered with a hot flannel jacket (which I think is admirable), but in most cases

I prefer giving the entire chest a rubbing with the following prescription:

Bisulphate of Quinine drams iss.
Dilute Acetic Acid drams iij.
Fluid Extract Capsicum drams j.
Glycerine qs., oz. ij.
M. Ft. Sol.

Sig: One teaspoonful rubbed well into skin over back and chest every three to four hours.

Vary the amount of capsicum in different cases, using more with older children and adults and less with the very young.

As for myself I am not a devotee of the great god Bacchus, and having no preference pass them all from Three Feathers through Family Disturbance to Planter Bee, but just because a few broad-minded mentors of the human family have arbitrarily classed alcohol among the undesirables and have even prevailed upon otherwise intelligent medical men to write long and pompous if not profound articles condemning it even as a medicinal agent, I do not propose to abandon the intelligent and proper use of this really valuable remedy.

Alcohol in the form of whiskey or nutrient elixir in small doses frequently repeated flushes the skin, relieves central tension around inflamed areas thereby relieving an overworked heart, lowers temperature by radiation, and promotes nutrition.

Proper administration of alcohol may mean the difference between nutrition and life and starvation and death in pneumonia.

Stimulation with strychnia, digitalis, nitro-glycerine, etc., is always a question to be decided at the bedside, but it is well to remember that most cases of pneumonia never need it.

In certain cases where cyanosis is a problem, oxygen where obtainable is comparatively easy of administration and may be life-saving, in tiding a patient over a critical period.

With pneumonia phylacogen or bacterin I have had no experience, but have been very doubtful of their value after carefully following the results obtained by those using them; will say however that results reported by Dr. Shafer and others using his phylacogen would indicate to me that we had best not condemn this remedy without personal investigation.

Expectorants, as such and in the form of the average cough mixtures, I only mention to condemn as worthless.

Proper administration of Dover's powder will do as much

or more than any of them toward relieving the cough and promoting expectoration and will accomplish several other much to be desired results at the same time.

I have not attempted to cover all the ground in this paper but have tried to attract attention to certain points hoping to stimulate discussion which is always better than the best of papers.

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*BETTER HEALTH CONDITIONS FOR THE COUNTRY: HOW OBTAINED.

JOHN M. GURNEY M.D.,
TUPELO.

We as physicians realize that the health conditions of our respective counties are far from what they should be, even in the light of our present knowledge; that epidemics are each year making inroads on our people and leaving them weakened by the effects of their poisons.

There are many deaths which seem untimely in our judgment and it is for this purpose that I present this paper today, that we may reduce the death-rate and sick-list by applying the knowledge which we have and instructing those among us who are in a large measure ignorant of the laws governing their bodies and the prevention of the afflictions of humanity which cause their premature death and render them unhappy while here, on account of not being able to enjoy those things which God has intended that His creatures should enjoy.

There are no statistics showing the per cent. of infectious and contagious diseases among our people that are reliable; if there were it would be my pleasure to present them to you for your consideration to-day.

However I will attempt to make an average estimate of the morbidity caused by some of the most common of these.

Malaria is by far the most prevalent among our people and I believe that the morbidity is as high as fifty per cent.; the mortality is not so high as we have a specific in quinine, but does that deter us from trying to prevent the disease?

Hookworm is the next in the list; though there has been no work of any consequence done in our four counties, the infection will reach forty or fifty per cent. There are annually

*Read before the East Mississippi Four County Medical Society.

many whose sickness and death are brought about by this disease, which we know, from reading so much about in the past year or two, is a preventable disease.

Measles claims for its portion in the neighborhood of five per cent. of our population; though considered by the laity and many of our profession as a necessary thing. The mortality is low without complications, but who knows when your complications are going to arise?

However common this disease or harmless as the general opinion goes in regard to it, we should stamp it from among us.

Scarlet fever, diphtheria and typhoid fever are the others to be considered.

Scarlet fever gives us quite a scare for it claims a large number of its victims. The morbidity is perhaps one-quarter of one per cent., while the mortality is high, as mentioned before.

Diphtheria is more common among us and we have again a specific, to come to our rescue in the time of great perils, in antitoxin. This disease claims for its list of sick some more than the one just mentioned, but the mortality is not so high on account of the early recognition and use of antitoxin.

Typhoid fever is not very extensive in this county, but I think I would be safe in saying that here are two cases to each thousand of population. A disease which we physicians know can be stamped out. One which, after long years of teaching, the people are ready to carry out the proper precautions to help prevent the spread of.

Lastily I mention the dreaded tuberculosis infections of our respective communities. From the statistics which I have at hand there are one hundred and sixty in each county in the state, with a mortality of twenty-five annually. Now I have given you a very conservative estimate of the conditions which prevail in our county, both as to the morbidity and mortality rate, I regret very much that I am unable to give you the real figures; for I believe they would far exceed those figures given and then you would become more concerned over the alarming condition of affairs and join in doing your part to at least reducing the preventible diseases, which are in a measure laid at your own door and you are partly responsible for; because you have failed to give the instruction for their prevention.

How can better health conditions be had in our counties?

This is the all-absorbing question of the entire State of Mississippi, as well as the entire nation.

The conservation of the health of our communities solves the problem of the state, yet we must go still further back to the individual. It devolves upon his intelligence and execution of the laws regarding hygiene, sanitation and prevention of the spread of disease.

Education of the general public as has been and is being done by our efficient State Board of Health is first, but they cannot do all the work requisite to the great task of impressing upon each individual the great work and responsibility of his being such an important integral part of the work in hand, of preventing the spread of disease.

The health officers must discharge their duties in bringing before the public such discussions as relate to preventive medicine, too, looking into the sanitary conditions or unsanitary conditions as they may find and instruct them as to measures to improve them.

Screening of houses to keep the mosquitoes out, though there are many who know this in a measure, they need to be told again and again, like all of the human family they need line upon line, precept upon precept.

Sanitary privies to reduce the number of hookworm and typhoid cases. Isolation or quarantine of those suffering from infectious diseases, immunizing of those people who are exposed, if it be a disease where such a thing is possible, as in smallpox, diphtheria, typhoid fever.

Treatment of the cases, which fall into our hands as physicians, in a vigorous way and at the same time doing our duty as we see it in reporting same to the proper authority; and giving such instructions as we feel it is our duty to prevent the spread of same.

This precaution may not be heeded by your clientele, yet you have discharged your duty as their medical adviser and counsel.

A closer relation among physicians, county health officers and the state officers must exist before the condition of better health can be had; for it is in keeping tab on the efficiency of the method we employ which allows us to say whether it is the right kind, or if changes are needed.

Let each of us do his whole duty and better health conditions will obtain in our county.

With better health conditions there will result better pay from those who we work for.' The loss column of physicians

is much larger than in any other business of which I know anything.

I dare say that every year it is between twenty-five and forty percent. Such an enormous loss and upon a class that is helpless on account of afflictions, could they remain well only for half the time and unhampered by the preventable diseases they would be able financially to meet their obligations to merchant and doctor alike.

As there must necessarily be remuneration for services rendered in proportion to the work done, it is time the county, separately, takes into consideration the work needed and appropriates the sufficient funds for the purpose.

The amount paid in Mississippi ranges from nothing to eighteen hundred dollars yearly; so does the work done range from nothing to eighteen hundred.

It is now time that Lee county and these three other counties which belong to this association take their place among those counties in the front ranks and conserve the most profitable and only real thing worth while, the health of their citizens?

Mississippi State Medical Association.

Meeting of Council and House of Delegates.—Monday, April 7th., 2 p. m.

General Meeting—Tuesday, April 8th.: Morning Session, 9 a. m.; Afternoon Session, 2 p. m., Evening Session, 8 p. m. Wednesday, April 9th.—Morning Session, 9 a. m.; Evening Session, 8 p. m. Thursday, April 10th.—Morning Session, 9 a. m.; Afternoon Session, 2 p. m.

All railroads entering Vicksburg give reductions to the meeting on the certificate plan. When you buy your ticket get a certificate.

MISSISSIPPI MEDICAL MONTHLY.

E. F. HOWARD B.S., M.D., Editor and Publisher.

S. MYERS M.D., Business Manager.

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OFFICIAL ORGAN OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION AND ITS COMPONENT SOCIETIES.

SUBSCRIPTION ONE DOLLAR PER ANNUM.

The City of Vicksburg and the Warren County Medical Society extend to every member of the Mississippi State Medical Association a cordial invitation to visit the widely famed and historic city of Mississippi, April 8th., 9th. and 10th. The program of the meeting, which has been already sent out, offers an intellectual treat, or series of treats, to any physician and the citizens of Vicksburg are going to see to it that what time can be spared from the business of the meeting will be pleasantly spent. We hope to break all attendance records. Please help us do it.

It gives the *Monthly* great pleasure to be able to present to its readers in this issue a likeness of the president of the State Medical Association, Dr. S. W. Glass of Lyon, and a brief sketch of his career. The latter does not go so fully into detail as we could wish, for we were obliged to rely on Dr. Glass himself for most of the data and he is so reticent and so modest that getting personal information out of him is hard work. The doctor modestly states that he is a member of the lower house of the legislature and chairman of its public health and quarantine committee. Those of us who were so fortunate as to see him in action during the last session of the legislature recognize him also as the man to whom the physicians and the people of Mississippi are most indebted for the revision of the medical practice act, and the passage of those laws that have enabled the State Board of Health to increase its public health work so greatly and to establish its bureau of vital statistics.

He will undoubtedly add new laurels at the next session of the legislature but these are enough to make us very proud of him and give us the greatest confidence in our official head.

Dr. S. Wade Glass.

Dr. S. Wade Glass was born and reared on a farm near Durant, Miss. After receiving a common school education he attended the Memphis Hospital Medical College, graduating with first honors in 1899. After serving a year as interne in the Mississippi State Charity Hospital at Vicksburg, he entered private practice at Dublin, where he resided until 1913, when he moved to Lyon.

Dr. Glass has served as president of the Clarksdale and Six Counties Medical Society, as vice-president of the Tri-State (Miss., Ark., Tenn.) Medical Association and as president of the alumni association of his alma mater. In 1911 he was elected to the lower house of the legislature from Coahoma County and is chairman of the Public Health and Quarantine Committee of that body. He is a member of the M. E. Church South, a Knight Templar, a Mason and Shriner and a B. P. O. E.

Society Proceedings.

East Mississppi Four County Medical Society met at Elks' Home, Aberdeen, Feb. 18th, 1913. The president being absent Dr. B. H. Durley was selected as presiding officer for the meeting. The secretary being absent Dr. R. M. Boyd was selected for this place. Interesting cases were reported by all present. The discussion finally terminated in an informal consideration of pellagra. Members present: L. C. Feemster, J. B. Sims, J. A. Dilworth, G. S. Bryan, B. H. Durley, F. E. Lee, W. J. Coleman, R. M. Boyd. The following paid their dues to the acting secretary: W. J. Coleman, J. B. Sims, R. M. Boyd. L. C. Feemster introduced the following resolution which was adopted.

Whereas, The Southern Medical Association is fulfilling a usefnl function in affording the medical men of its territory opportunity for expression and for mutual improvement; and

Whereas it is co-operating with other organizations, both National and State, for the progress of the profession; be it

Resolved, That the East Mississippi Four County Medical

Society endorses the Southern Medical Association and urges its members to join in its upholding.

There being no further business the meeting adjourned to meet in Amory the third Tuesday in March.

R. M. Boyd.

Book Reviews.

PRINCIPLES AND PRACTICE OF OBSTETRICS. By Joseph B. De Lee A.M., M.D. Professor of Obstetrics at the Northwestern University Medical School. Large Octavo of 1060 pages, with 913 illustrations. 150 of them in colors. Philadelphia and London: W. B. Saunders Company. 1913. Cloth, $8.00 net; Half Morocco, $9.50.

It has long been a wonder to the reviewer why De Lee had not written a book on this subject, for there are few, if any, American obstetricians better or more favorably known. With ample experience and a clear, concise manner of expression the author has produced a volume that would be impossible from the pen of almost any other writer. It is positively the latest word on the subject.

Modelled on the author's "Notes on Obstetrics," which the students of the Northwestern University Medical School swear at and its graduates swear by, the book is divided into four parts, the physiology of pregnancy, labor and the puerperium; the hygiene and, conduct of pregnancy, labor and the puerperium; the pathology of pregnancy, labor and the puerperium; and operative obstetrics. It is too comprehensive for a text-book if the student be not aided, so the essentials are treated in ordinary eleven-point type and the wealth of detail, so essential to the practitioner, in eight-point, an arrangement somewhat unusual but which should prove of no little value. The illustrations, some drawings—some photographs, are excellent and exemplify the marked advance in bookmaking in recent years.

E. F. HOWARD.

PSYCHANALYSIS: Its Theories And Practical Application. By A. A. Brill, Ph.B., M.D., Chief of the Neurological Department of the Bronx Hospital and Dispensary; Clinical Assistant in Psychiatry and Neurology at Columbia University Medical School. Octavo of 337 pages. Philadelphia and London: W. B. Saunders Company, 1912. Cloth, $3.00 net.

What is Psychanalysis will be the question the average man will ask himself? The volume answers it completely; it is a system of psychoteraphy that deals with the neuroses as entities instead of treating symptoms as do hypnotism, suggestion and persuasion. "Psychanalysis always concerns itself with the individual as a personality and enters into the deepest recess of the mind."

It is based almost entirely about the researches of Freud and knowledge of psychology is essential to its practice as the author says, "a knowledge of Freud's theories of sex is essential because as soon as we enter the intimate life of a patient we find sex in some form.

The study of psychanalysis and its practice is undoubtedly very fascinating and if the personal equation of the practitioner, his own imagination, did not play an important role, it would undoubtedly be the key that would unlock the secrets of every mind. Its basis is truth, and here we undoubtedly have the germ which will bear fruit in the distant future. To trace a man's motives through his acts, and supply the missing links is undoubtedly a most fascinating game, but one to be played by imaginative people.

S. MYERS.

INTERNATIONAL CLINICS. A Quarterly of Illustrated Clinical Lectures and Especially Prepared Original Articles. J. B. Lippincott Co., Philadelphia. Vol. IV, Series 22. Price $2.00.

The biography of Benjamin Rush which appears in this issue is sufficient reason for the publication of the volume. We should all have some knowledge of the pioneers, and Rush played no small part in the affairs of his day. The jump from the middle of the eighteenth century to the present time is emphasized by a description of the Rockefeller institute, in which too much space is wasted in pictures of chemical laboratories and floor plans. Probably the most valuable article from a purely professional standpoint is Bergouignan's "Features Of The Normal Heart," which should prove of interest to every physician, especially those engaged in life insurance work.

E. F. HOWARD.

SURGERY AND DISEASES OF THE MOUTH AND JAWS. V. P. Blair A.M., M.D., Professor of Oral Surgery, and associate in Surgery, Washington University Dental School. C. V. Mosby Medical Book and Publishing Co., St. Louis. Price $5.00.

Dr. Vilray Poplin Blair's recent work on Surgery and Diseases of the Mouth and Jaws is to be commended. It will prove a valuable reference not only to the surgeon, but also to the general practitioner of both medicine and dentistry. His description of and the surgical relief for the various pathological conditions of the mouth and jaws and teeth as well as the accidents which often occur thereto, is well illustrated and quite complete. Though some few dental operations which he mentions and advises are rather brief, it does not appear as a lack of familiarity with the subject under discussion. The author in the main does not claim originality for his methods employed when surgical interference is necessary, but describes the methods of others, giving the advantages and disadvantages of each, and adds his experience with frequent suggestions which deserve careful consideration.

J. B. ASKEW.

TEXTBOOK OF OPHTHALMOLOGY in the form of Clinical Lectnres by Dr. Paul Roemer, Professor of Ophthalmology at Greifswald. Translated by Dr. M. L. Foster, Vol. III. Rebman Co., 1123 Broadway, New York. Price $2.50.

This volume, completing a work which is a real addition to ophthalmic literature, carries out the original plan commended in the previous volumes and is interesting and instructive from first to last. The subjects considered are the pupil, pareses of the ocular muscles, neurology of the eye, diseases of the choroid, optic nerve and retina and functional testing of the eye.

The chapters on the pupil, pareses of the ocular muscles and neurology of the eye including 125 pages cover not only the eye lesions but the various eye symptoms of general nervous diseases and the value to be placed on them. The diseases of the choroid, optic nerve and retina are considered more briefly but in a very satisfactory manner.

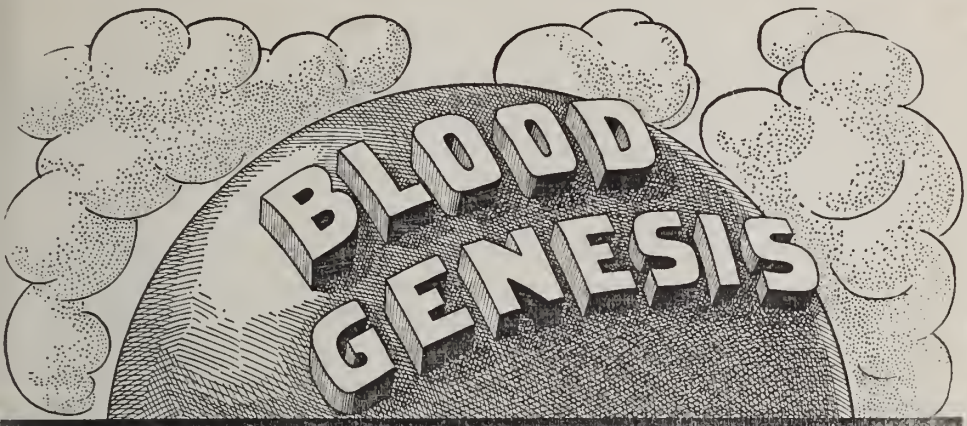
In the chapter on functional testing of the eye, myopia receives full consideration but the rest of the subject is not well handled. Few American ophthalmologists will agree with the author that it is wrong to fit cylindrical glasses while the pupil is dilated by atropin. An appendix is added by Dr. Foster on asthenopia, or eyestrain which is more in line with the American teaching on this subject.

This volume also contains a complete list of the illustrations and plates and a very complete index, covering the whole work.

The reviewer would note a mistake in the binding, Vol. 1 is appreciably smaller than the other two.

The publishers announce that when the present small issue of this work is exhausted it will be bound in one volume, cloth, at $7.50 the volume.

M. H. BELL.



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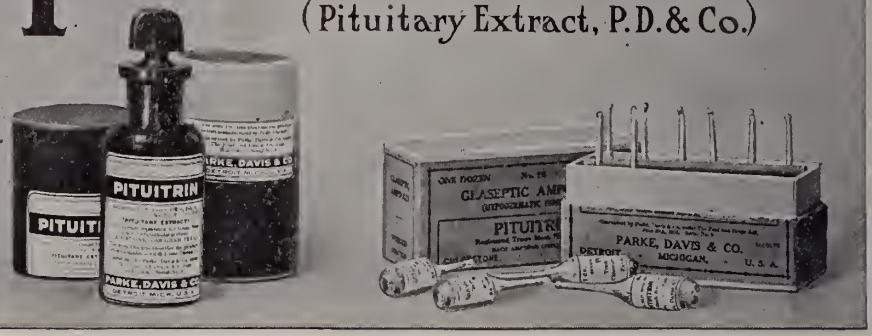

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Dr. J. Hofbauer, of the Gynecological Clinic of the University of Königsberg, in the *Centralblatt für Gynækologie*, tells of twelve obstetrical cases in which he used Pituitrin as a means of exciting and aiding labor pains. "In the entire twelve cases the results were remarkable. . . . There were no unfavorable after-effects."

In another issue of the same journal Dr. Otto Fischer, of the Gynecological Clinic of the University of Würzburg, records his experience in fifty cases, showing the wonderful power of Pituitrin in overcoming uterine inertia and obviating the use of instruments in childbirth. He refers to Pituitrin as "a very valuable addition to the materia medica, especially because its principal action pertains to a domain in which there has been a long-felt demand for a dependable medicament."

Dr. Alfred Studeny, in the *Wiener Klinische Wochenschrift*, refers to the use of Pituitrin in a large number of cases of childbirth at the Moravian lying-in institution at Bruenn. "In summing up our experiences," says Dr. Studeny, "we would designate Pituitrin as the most reliable ecbolic agent known at the present time."

In the *Münchener Medizinische Wochenschrift* Dr. Emil Vogt, of the Royal Gynecological Clinic at Dresden, says: "In the second stage of labor the action of Pituitrin is prompt and certain. It serves to accelerate normal deliveries, and may be used to combat secondary insufficiency of labor pains even in cases of narrow pelvis."

Dr. Hans Hermann Schmid, First Assistant of the Obstetrical Clinic of the University of Prague, in the *Gynecologische Rundschau*, declares Pituitrin to be "the only certain and safe ecbolic medicament that can be used to advantage in cases in which the forceps or a dilator has heretofore been employed."

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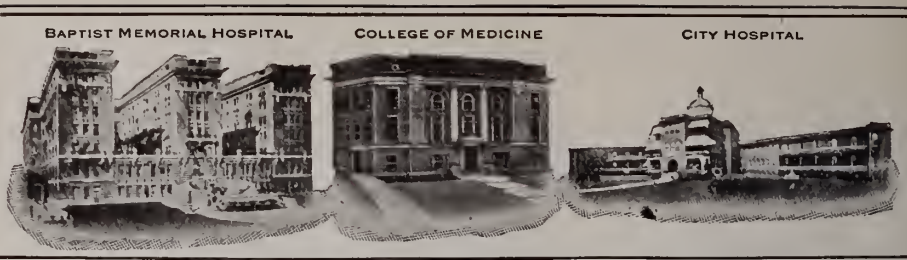

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is the title of a speech made by U. S. Senator W. B. Heyburn, of Idaho, May 25th, 1912. This speech has been issued in document form by the American Protective Tariff League as document No. 4. Send postal card request for free copy to W. F. Wakeman, Sec. 339 Broadway, New York.

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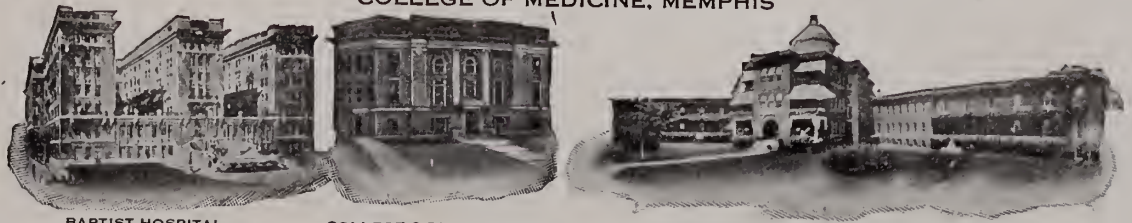

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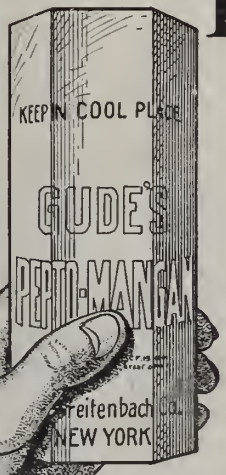

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THE ICE BAG IN APPENDICITIS.

In a most interesting article by A. M. Fauntleroy, Surgeon of the United States Navy, Medical Record, Aug. 3, 1912, the fact is brought out, basing the same upon a large number of cases of appendicitis operated, that the ice bag is positively harmful in this condition. In 50% of the cases operated, where the ice bag was used, the condition seemed to indicate that there was a noticeable lack of effort on the part of nature to wall off, from the rest of the abdominal cavity, the appendix, which was frequently very much congested, gangrenous or perforated. He also observed that in the ice bag cases there was a surprisingly low white cell count when one took into consideration the condition found in the abdomen at the time of the operation. From 8,000 to 11,000 white cells was the rule in these ice bag cases when one would be justified in saying that the pathological condition warranted a constitutional reaction of from 20,000 to 30,000 leucocytes, or even higher.

On the other hand, in those cases in which the hot water bag or morphine had been used prior to operation (the ice bag not being used at all), the white count corresponded to what one would expect. Dr. Fauntleroy advances from his findings the logic that while the ice bag causes numbness, practically the same as in the condition of frost-bitten ear or toe, it also decreases hyperemia, leucocytosis and stasis in the part to which it is applied. That heat is the direct antithesis of cold in encouraging favorable physiological action in inflammatory processes, whether superficial or peritoneal, seems to be from his report most logically and conclusively proven.

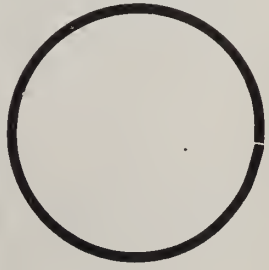
In applying heat whether it be for peritoneal or inflammatory conditions of a more superficial character, the most rational method is to use that which is not only sanitary, but, for the comfort of the patient does not require frequent changes. In this respect, antiphlogistine, on account of its heat retentive properties, its cleanliness, and its ease of application should appeal to the professional mind. That antiphlogistine has proven of great therapeutic value as a thermic agent is best indicated by its extensive professional employment and its many advantages over the hot water bottle and other methods of application of heat is readily discernible.

"there is no surgeon of any experience who is not convinced of the soundness of the principle which underlies Bier's hyperemic treatment, and this being accepted there is every reason to discard the ice bag since the latter brings about a condition directly opposite to what we strive to accomplish in carrying out this principle in the treatment of inflammation involving the peritoneum." Dr. A. M. Fauntleroy, Surgeon, U. S. Navy, ***Medical Record,*** August 3rd.

Dr. Fauntleroy demonstrates that while the ice bag relieves pain by practically producing numbness as in a frost bitten toe or ear, it also decreases hyperemia, leucocytosis, and encourages stasis in the part to which it is applied.

That heat is the direct antithesis of cold in encouraging favorable physiological action in inflammatory processes, whether superficial or peritoneal, here seems to be most logically and conclusively proven.

That antiphlogistine affords the most convenient, sanitary and satisfactory method of utilizing heat as a therapeutic agent would also seem conclusive from its extensive employment by the medical profession.



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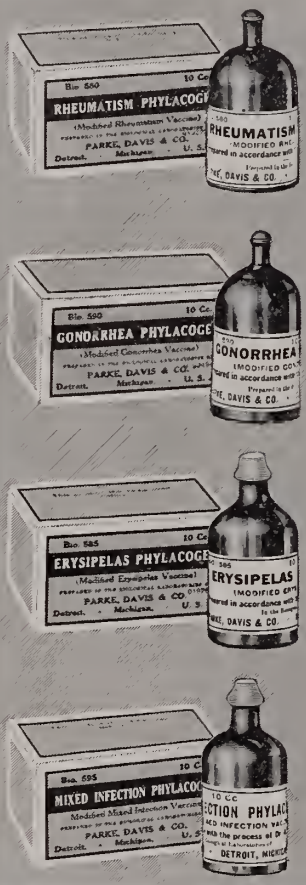

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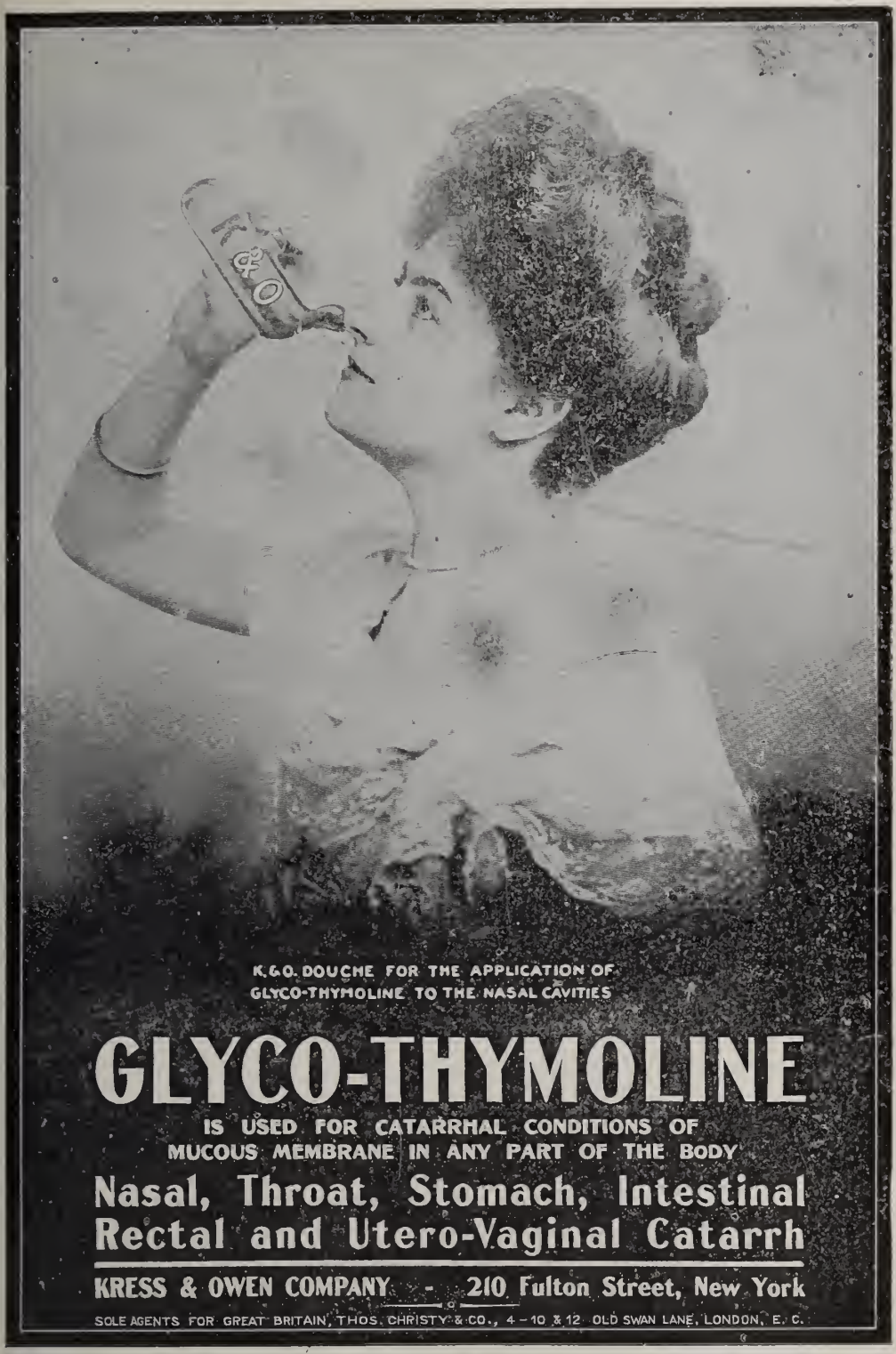

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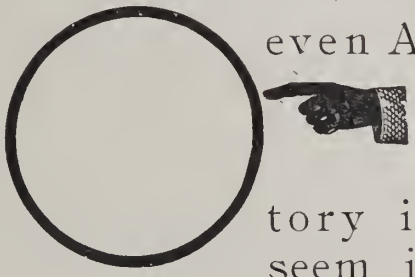
In view of the fact that hypernutrition, or so-called forced feeding constitutes one of the important indications in the treatment of many cases of tuberculosis, more than ordinary attention must always be devoted to maintaining the appetite. Unfortunately, many of these patients have an aversion to the very foods which are best adapted for repairing and resisting the ravages of the disease. It is here that Gray's Glycerine Tonic Comp. serve one of its most important purposes, by reason of its notable capacity to awaken a deficient appetite in a perfectly natural manner. It not only possesses the desirable feature of great palatability but through its tonic properties, it never fails to impart just the right tone to the digestive organs. Thus the effects are so much more permanent and far-reaching than are obtained from ordinary stomachics, that not only are larger quantities of nourishment freely taken by the patient, but a correspondingly increased amount finds its way to the remote tissues.

"the value of cold as a therapeutic agent in inflammatory conditions is slowly but surely reversing from a fact into a very doubtful theory.

Dr. Cavana (*American Journal of Surgery*, Oct. 1912) demonstrates by careful analysis and logic that pathogenic micro-organisms multiply most rapidly in a temperature from above 98.6° to freezing and "that in a temperature of 100° Fahrenheit most of the laboratory cultures die, and that in a temperature of 103° all artificial germ propagation ceases."

Taking a case of Pneumonia, Tonsillitis, Bronchitis, even Appendicitis, as Dr. Fauntleroy suggests, in fact any inflammatory involvement, it would seem justifiable and logical in the light of this reasoning that heat, best applied in the form of antiphlogistine, facilitates a cure by favoring leucocytosis and adding to nature's defense against suppuration.



There can be no doubt that much of the success in treating inflammations, whether deep or superficial, with antiphlogistine which retains its thermic value for hours if applied thick and hot, has been due to this therapeutic function."

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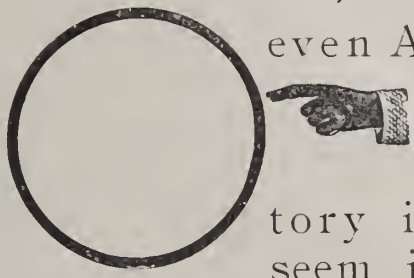
"the value of cold as a therapeutic agent in inflammatory conditions is slowly but surely reversing from a fact into a very doubtful theory.

Dr. Cavana (*American Journal of Surgery*, Oct. 1912) demonstrates by careful analysis and logic that pathogenic micro-organisms multiply most rapidly in a temperature from above 98.6° to freezing and "that in a temperature of 100° Fahrenheit most of the laboratory cultures die, and that in a temperature of 103° all artificial germ propagation ceases." Taking a case of Pneumonia, Tonsillitis, Bronchitis, even Appendicitis, as Dr. Fauntleroy suggests, in fact any inflammatory involvement, it would seem justifiable and logical in the light of this reasoning that heat, best applied in the form of antiphlogistine, facilitates a cure by favoring leucocytosis and adding to nature's defense against suppuration.



There can be no doubt that much of the success in treating inflammations, whether deep or superficial, with antiphlogistine which retains its thermic value for hours if applied thick and hot, has been due to this therapeutic function."

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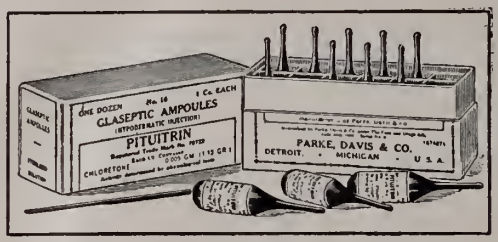

Read this tabulated report of eight cases under the observation of Dr. Oscar Bondy, of the Gynecological Clinic of the University of Breslau, and reported by him in the *Berliner Klinische Wochenschrift:*

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34 hours.	45 minutes.
44 hours.	30 minutes.
48 hours.	15 minutes.
23 hours.	5 minutes.
36 hours.	35 minutes.
27 hours.	60 minutes.
44 hours.	10 minutes.
32 hours.	29 minutes.
Average, 36 hours.	28 minutes.

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Careful attention to feeding is, of course, a *sine qua non* and the details of the infant's nourishment should be carefully investigated and regulated. But this is not all. Many bottle-fed babies are below standard from a hematologic standpoint. The marasmic anemic baby deserves special attention in the way of building up and restoring a circulating fluid which is deficient in red cells and hemoglobin. In the entire Materia Medica there can be found no direct hematic quite as suitable for infants and young children as Pepto-Mangan (Gude). In addition to its distinctly pleasant taste, this hemic tonic is entirely devoid of irritant properties and never disturbs the digestion of the most feeble infant. Being free from astringent action, it does not induce constipation. A few weeks' treatment with appropriate doses of Pepto-Mangan very frequently establishes sufficient resisting power to enable the baby to pass through the hot summer without serious trouble, gastro-intestinal or otherwise.

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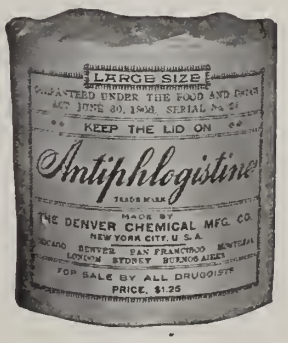

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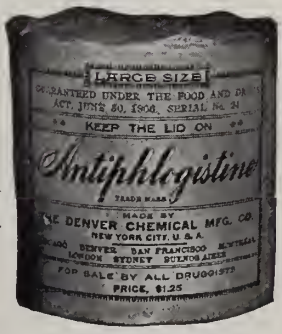

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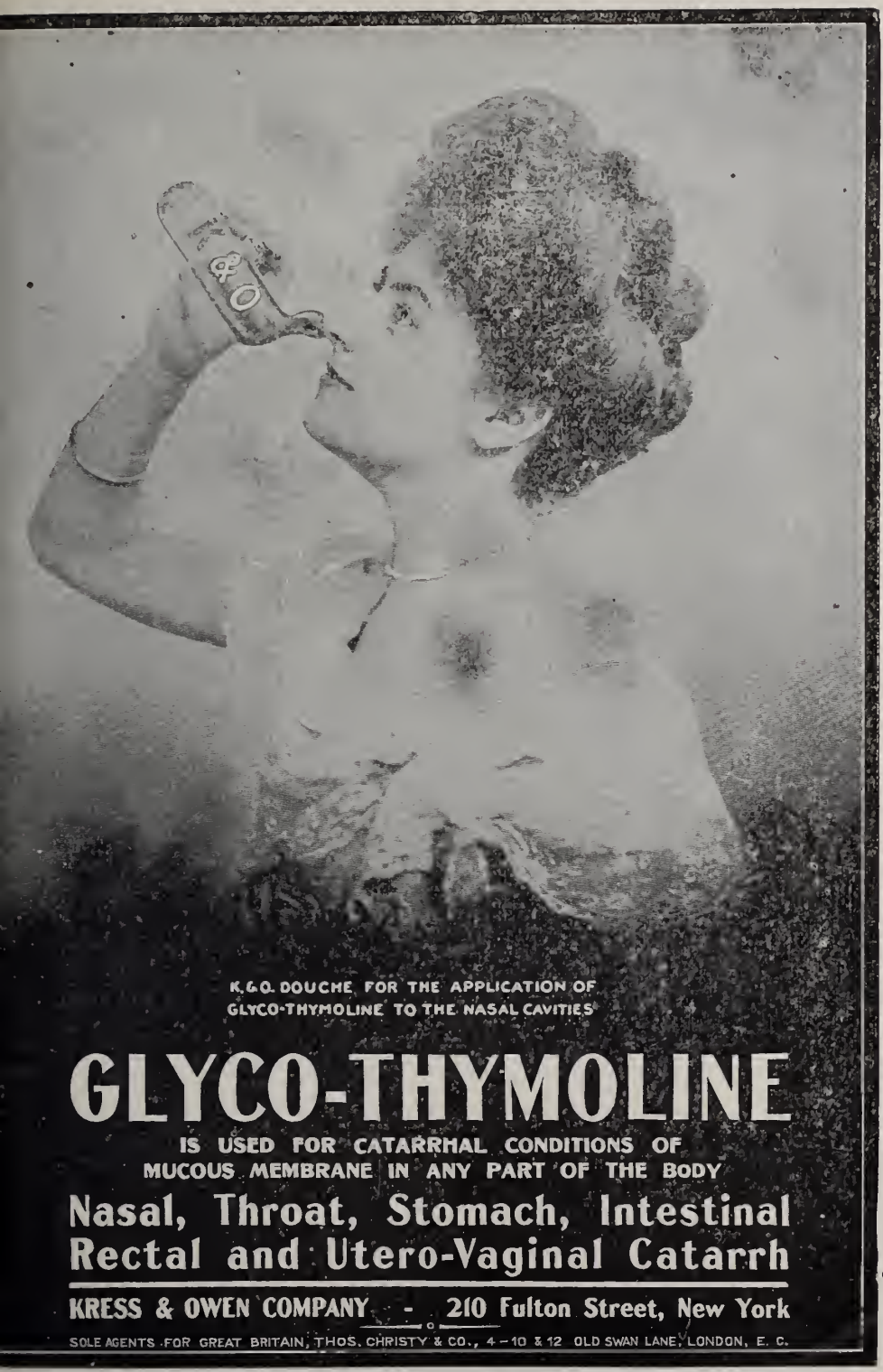

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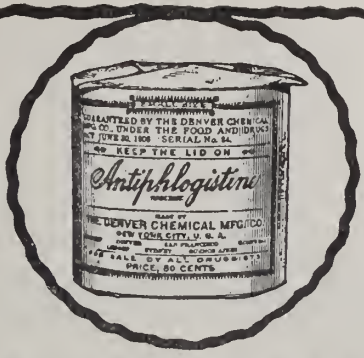
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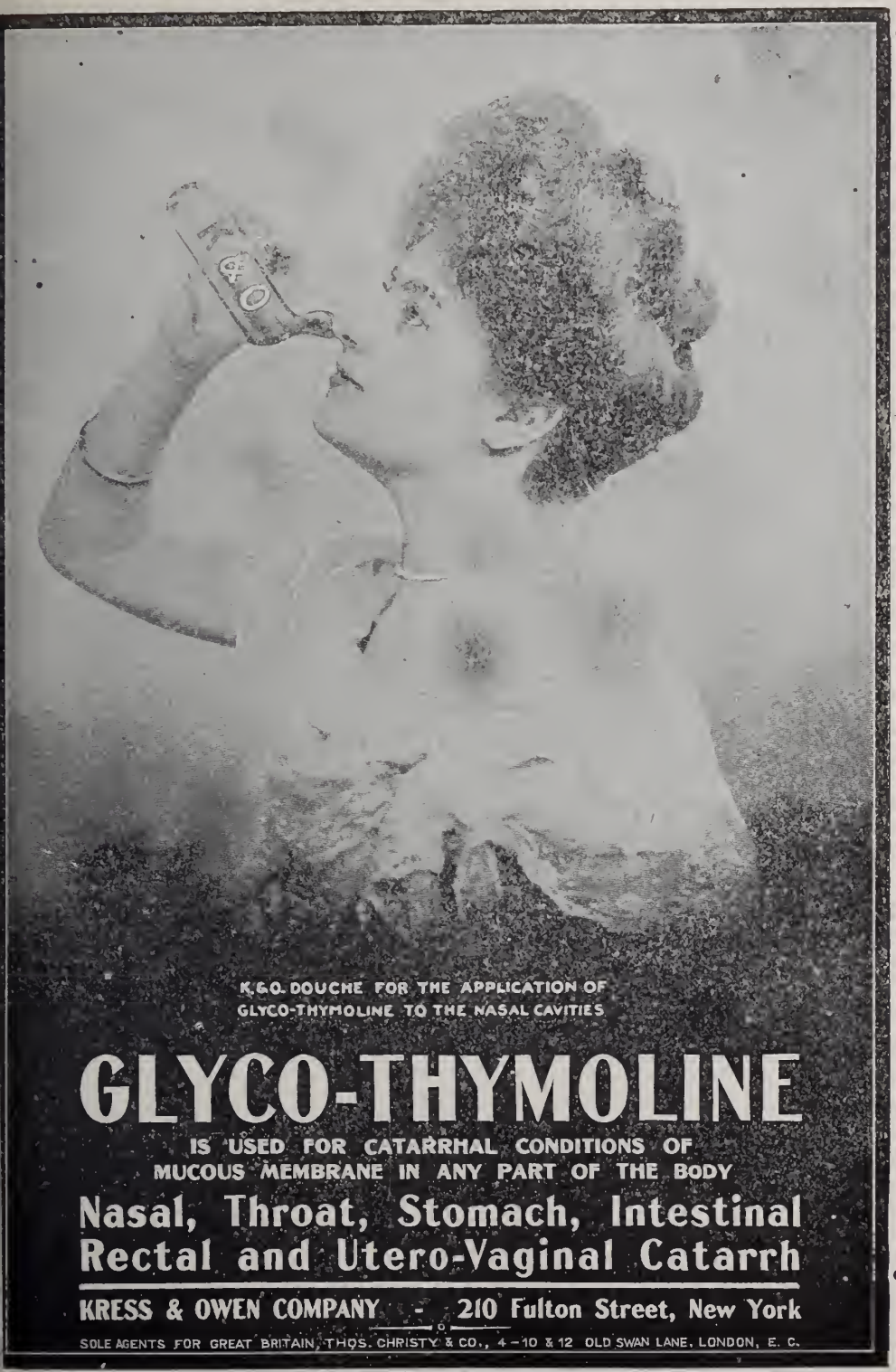
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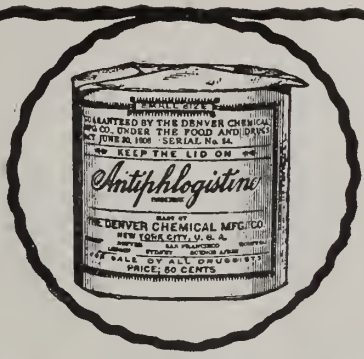
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Vol. XVII. JUNE 1912. No. 2.

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SURGICAL
AND
RECTAL DISEASES

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Consulting Physician, St. Joseph's Hospital.
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Vol. XVII. JULY 1912. No. 3.

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Effervescent Tablets of { **Cystogen 3 grains** / **Lithium tartrate 3 grains**

Uric acid Solvent, alkaline urinary antiseptic.

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SURGICAL AND RECTAL DISEASES

Dr. B. G. Henning,

Professor Theory and Practice of Medicine, Memphis Hospital Medical College.
Clinical Instructor in Diseases of the Rectum, Memphis Hospital Medical College.
Consulting Physician, St. Joseph's Hospital.
Surgeon to Rectal Dept., St. Joseph's Hospital.
Surgeon to L. & N. R. R.

Dr. Max Henning,

Clinical Lecturer Diseases of Rectum, Memphis Hospital Medical College.
Clinical Lecturer in Surgery, Memphis Hospital Medical College.
Demonstration of Operative Surgery, Memphis Hospital Medical College.
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WANTED—Practice of $2,000.00 or more in Mississippi. Would consider some Real Estate or Drug Stock.

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may be confidently relied upon to stimulate the appetite, promote digestion, increase assimilation, and not only restore functional vigor, but also build up the whole organism.

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NEW YORK AND LONDON.

Vol. XVII. NOVEMBER 1912. No. 7.

MISSISSIPPI MEDICAL MONTHLY

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Complete splitting is now known to be the "fate of the proteins", and these cleavage products believed to be *the* proteins essential to nutrition. Panopepton contains these proteins, a great part of them in the state of ultimate cleavage in which they are immediately available for nutrition.

Our literature about Panopepton is chiefly technical; we do not talk about the diseases in which it is used; it is the food itself to which we call attention---how it is obtained, its character, its actual content. The label carries the guaranteed analysis.

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MISSISSIPPI STATE BOARD HEALTH, JACKSON, MISSISSIPPI.

On December 10th, the first returns were received by the Bureau of Vital Statistics of the births and deaths as collected under the Vital Statistics Law, and Dr. F. L. Watkins, Deputy State Registrar, who has had the opportunity of inspecting similar reports in several states, says that the report as received by the State of Mississippi is as good as any that he has ever seen in any state, and in some respects much better. With a very few exceptions, the reports have been complete, and the success of this law seems assured. More than half of the reports of the Local Registrars reached the Office on the morning of the 11th, and the report, no doubt, will be complete by the 15th.

The people of the State of Mississippi are to be congratulated in complying with this law in the manner that they have, as it is one of the most important laws that has been passed by the Legislature.

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Vol. XVII. JANUARY 1913. No. 9.

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Vol. XVII. FEBRUARY 1913. No. 10.

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